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Original Articles.

ON AN ILL-DEVELOPED UPPER LATERAL INCISOR TOOTH AS A FORERUNNER OF HARELIP OR CLEFT PALATE.*

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THERE is a tendency and often a desire to represent a congenital deformity as something which has suddenly developed *de novo* and as a defect which is to be explained by some accidental occurrence during pregnancy or labour. An enormous amount of ingenuity is in many cases expended by the parents, relations, friends, and even the family doctor, to place the defect before the world as a mere accident that would never have occurred if such and such a sight had not by chance been encountered by the mother during her pregnancy, an incident that occurred probably long after the establishment of the defect *in utero*, and entirely forgotten till raked up to explain away the unfortunate deformity in the child. Superstitions die hard even in a highly civilised and generally intelligent community, and blame is an imputation which every one desires to

* Read before The Society for the Study of Disease in Children, October the 21st, 1904.

transfer from himself to his neighbour; or should no one be found conveniently placed to bear it, then a spiritual influence that cannot be questioned is usually called in to account for what natural causes may still be able to explain.

I have attempted to show that in the case of harelip and cleft palate there may have been through generations an unnoticed defect in the natural line of junction between the incisor bone and maxilla. Then the marriage with another who by chance has inherited through some ancestor a weakness of development in the same part, or possibly, simply as the result of deprivation of proper nutriment during the developing period, a well-marked distinct and obvious deformity noticeable by all may become developed.

Besides the ingrained tendency to adhere for all time to superstitions which fancy favours, however reason rebels, there is another very human faculty, which is to accept nothing new from any one with whom one has the slightest acquaintance, unless perchance it has first been published in a foreign language as the observation of some distinguished foreign professor. Thus, sound observations often lie dormant for years till some honest worker in the same field unearths what might have prevented many fallacies had it been tested, and proved or discarded, shortly after the observation had been made. From this neglected heap I dig up the following observations published sixteen years ago.

In the Clinical Society's 'Transactions' for the year 1888, page 64, I published a short paper "On the Congenital Absence of an Upper Lateral Incisor Tooth as a Forerunner of Harelip and Cleft Palate." There were three observations bearing upon this relation in the paper referred to. In the first a gentleman who, as a boy, was noticed to have an absence of the left upper lateral incisor, had an only daughter who presented precisely the same defect on the same side. As this only child has never married there is no chance of proving the relation of the defect to harelip and cleft palate in that family. It proves, however, that the congenital absence of an upper lateral incisor tooth is a defect which may be transmitted, and that the transmission may be through the opposite sex.

The second case was brought among my out-patients at the Evelina Hospital in 1883. An infant suffering from harelip on the right of the median line was brought by a mother who had congenital absence of the right upper lateral incisor tooth. The mother was twenty-five years of age, had been married seven years, and this was her fifth child. There was an interval of one year and eight months between this child and the one

before, and she had continued to suckle until she fell pregnant again. The mother's lip was perfectly normal. There was no notch or scar upon it, but her right upper lateral incisor was known to have been absent, and it had never been extracted. The other teeth were well formed. The child had also double inguinal hernia and an umbilical one. It would seem that the exhaustion of the mother by repeated pregnancies and prolonged suckling was a factor in determining the appearance of the deformity.

The third case was that of a child with harelip and cleft palate on the left side, whose mother had absence of the left upper lateral incisor tooth. She was twenty-three years of age, and this was her first child. They came under observation in April, 1887. The mother was one of a large family, none of whom had shown any deformity. She was a pale, delicate-looking woman. A sister and an aunt had died of consumption. She knew of no defect in her husband's family. Her lip was perfect. She was positive that no tooth had ever been extracted from the front of her mouth, though she had lost one or two molars.

From these observations I concluded that *the absence of an upper lateral incisor tooth resulting from an arrest of development is to be regarded as a malformation closely related to harelip and cleft palate, and capable of transmitting each or both of these deformities to a succeeding generation.*

I have now to record two further observations which show that a lesser deformity than congenital absence of the upper lateral incisor tooth, and one more likely to be overlooked, may indicate the possible occurrence of harelip or cleft palate in a subsequent generation. These observations, which I mentioned in the Wightman lecture, go to show that a defective development in an upper lateral incisor is a danger signal in reference to these deformities which should not pass unnoticed.

Case I.

Right-sided harelip and complete cleft palate in the first child of a mother who had an imperfectly developed right upper lateral incisor tooth, and who had been operated on for harelip in childhood.

E. R—, aged 3 months, was first admitted under the late Mr. Durham's care into Guy's Hospital on October the 8th, 1892, and was discharged without operation on January the 27th, 1893.

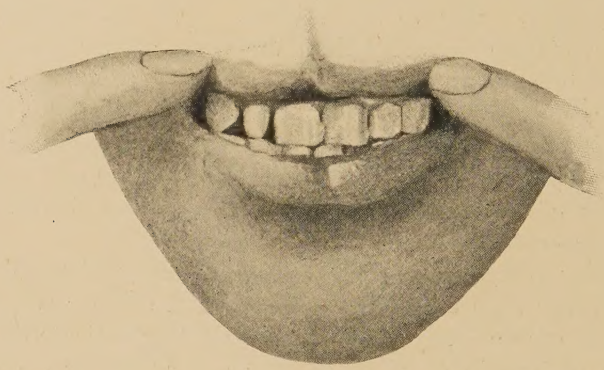
She was readmitted under Mr. Clement Lucas's care in Lydia

Ward, on July the 26th, 1893, and the case was reported by Mr. F. W. Rowland.

The mother showed the scar of an operation in childhood for harelip, but the defect had not extended to the palate. The teeth were all well developed except the right upper lateral incisor, which was narrow and pointed towards the end. A painting was made of this condition by the artist to the hospital.

The infant, a girl, presented an oblique fissure through the upper lip to the right of the median line extending into the nostril. On the left side of the fissure the premaxillary bone projected prominently forward, and to the right. The cleft extended backwards along the roof of the mouth through the alveolus and hard

Fig. 1.



and soft palate. The fissure in the lip was about a quarter of an inch in width, whilst that in the palate was about half an inch. The child was extremely thin.

On August the 18th the harelip was operated on, and on August the 24th, complete union having taken place, the child was discharged.

Case II.

Harelip in an infant whose mother had a perfect lip, but an ill-developed upper lateral incisor on the same side as the child's harelip.

W. J—, aged 6 weeks, a boy, was admitted into Martha Ward, Guy's Hospital, on June the 10th, 1903, and discharged on June the 20th as he was not in a fit state for operation.

He was readmitted on August the 17th, 1903, and discharged on September the 18th after operation.

The case was reported by Mr. F. J. H. Wood. The patient was the first child of young parents. The left side of his upper lip presented a cleft which extended up into the left nostril. The left

Fig. 2.

nostril was much wider than the right. The mother knew of no deformity of the kind either in her husband's or in her own family. Her own upper lip showed no defect, but Mr. Lucas, on examining her teeth, pointed out that she had a remarkable narrow ill-developed upper left lateral incisor tooth which he considered was related to the deformity in the child. The mother's teeth were photographed, and a sketch was also made showing the relative size of the defective tooth to the others, which were all large, well-developed teeth.

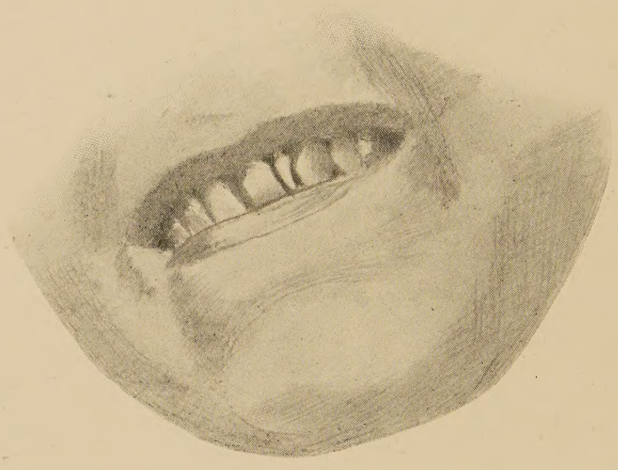
September the 8th.—The harelip was operated on and sealed iodoform dressings were applied over.

September the 11th.—The sutures were removed.

September the 18th.—He was discharged cured.

When I read my paper sixteen years ago, On the Absence of the Upper Lateral Incisor as an Indication of the possible Occurrence of Harelip and Cleft Palate in a Succeeding Generation, some dental surgeons present declared that the lack of eruption of certain teeth of the second set was a matter of common observation, and that no clinical importance need attach to it. But what I wish to again insist upon and to maintain is, that with a weakened development in

FIG. 3.



the line of junction between the pre-maxillary and the superior maxillary bones the lateral incisor tooth becomes involved in the defect, and may either fail to be cut or, if erupted, may show a defective development that is a danger-signal as to results which may happen in subsequent generations. It will be observed that the obvious secondary deformity may show itself in the soft structures alone as a harelip, or both palate and lip may be involved in the next generation.

So far, I have no observations on the condition of the milk teeth in these cases, but I think it highly probable that the primary teeth may indicate the defect as well as the second set.

It is seldom that one has an opportunity of examining the father's teeth, but, as in the first observation made, the absence of a lateral

incisor was transmitted to a daughter, it shows the necessity of examining the teeth of both parents to obtain evidence of a prior defect.

Further, it must not be expected that every child of a person showing defective development or absence of an upper lateral incisor should inherit either the same or an increased deformity; and although most of those recorded were first children born, in one case four normal children were born before a deformed child appeared.

FOREIGN BODIES IN THE EYES OF CHILDREN.

By Sydney Stephenson, C.M., F.R.C.S.E.,
Editor of the 'Ophthalmoscope.'

To be called upon to remove a foreign body from the eye must be an almost daily event in the life of most busy practitioners. Yet it is astonishing how frequently the presence of these substances is overlooked, more especially in young children, who seldom if ever are capable of giving a clear history. In grown-up people these mistakes occur comparatively seldom, since in most cases the patient is fully aware of what has happened, or else gives an account of pain and discomfort having suddenly begun at a moment when he was exposed to the intrusion of foreign substances, as when riding outside an omnibus, leaning out of a railway carriage window, and so forth. Still, every ophthalmic surgeon is, unfortunately, familiar with cases where the inflammation resulting from such a cause has been treated, while the cause of the inflammation, in the shape of a foreign body, has been overlooked altogether.

Foreign bodies in the eye may be of the most varied nature, but the things commonly met with include bits of coal, coke, or cinders, tobacco ash, particles of metal or grit, flies, and insects of different kinds.

When the presence of a foreign body is suspected, the first step is to make a careful examination in a good light. Difficulty is frequently experienced in doing this, since the foreign body often causes lacrymation, spasm of the eyelids, and dread of light, symptoms that in children especially tend to render such an examination anything but an easy task. Some help can, however, be got if the child be persuaded to keep his uninjured eye opened during the investigation.

In particularly difficult cases a general anæsthetic should be administered, and under these circumstances ethyl chloride is very suitable. But in whatever way the end is attained, a careful scrutiny must first be made of the cornea and of as much of the ocular conjunctiva as is exposed to view when the eye is opened. The lower lid is next drawn down, and its conjunctival surface examined. After that, the upper lid is everted, and its conjunctival surface carefully scrutinised for a foreign body. The last step of all, supposing the previous search has yielded negative results, is to expose the superior *cul-de-sac*—that is to say, the folds of conjunctiva that lie above the upper eyelid. In tractable patients this may often be brought into view by pressing the eyeball upwards while the upper eyelid is held everted. In patients who are under the influence of a general anæsthetic, there is seldom any serious difficulty about exposing the folds. In the last resort, a camel-hair or sable brush, moistened with boric lotion, may be passed into the *cul-de-sac*, and used to sweep the folds in the hope of entangling the intruding substance and of thus removing it. Syringes have been used for a similar purpose. One obvious precaution should invariably be adopted, namely, when a foreign body has been removed, say, from the surface of the cornea, never neglect to search the other parts of the eye, in order to make sure that a second body is not left behind. I have seen this mistake made on several occasions by those whose experience should have precluded anything of the kind.

A solution of cocaine or holocaine, so useful in adults, when dropped into the eye prior to the removal of a foreign body, is of little or no service when dealing with young and timid children. Darier* has recommended that a 5 per cent. solution of the new morphine derivative, dionine, should be applied in cases where the substance is lodged in the cornea, in order that it may become loosened before any attempt is made to remove it. For my own part, I have never found it necessary to resort to this somewhat roundabout process.

It is a familiar observation that some individuals are peculiarly prone "to get things into their eyes." In such cases the eyelashes will invariably be found to be thin and scanty. It is necessary to observe that the suffering caused by a foreign body depends upon several factors, of which perhaps the most important are the smooth or rough surface of the substance, the precise position where it is lodged, and the sensitiveness or otherwise of the patient to pain. It may also be pointed out that the symptoms do not, as a rule,

* Darier, 'Die Ophthalmologische Klinik,' July the 5th, 1904.

simulate those of any kind of conjunctivitis, as the text-books insist. On the contrary they remind one far more closely of an inflammation of the cornea, including, as they do, photophobia, ciliary redness, lacrymation, blepharospasm, and pain. The tolerance of an eye to the intrusion of foreign bodies is sometimes surprising. When I was in charge of the Ophthalmic School at Hanwell, an institution primarily intended for poor-law children afflicted with trachoma ("granular lids"), the eyelids of most of the inmates, over 300 in number, were everted frequently to admit of the application of remedies to the diseased conjunctiva. On windy days I have often removed foreign bodies, sometimes of large size, from the conjunctiva, of whose existence the children were altogether unconscious. Complaints, indeed, were the exception rather than the rule.

We distinguish between foreign bodies in or upon the conjunctiva and the cornea.

Conjunctiva.—Nine times out of ten the foreign body lodges on the inner surface of the upper lid, in a small groove (the sub-tarsal sinus) which runs parallel with the free border of the eyelid. Pain and discomfort are then considerable, owing to the cornea being continually fretted by the movements of the upper eyelid. Removal is quite a simple affair. It is merely necessary to evert the eyelid, and to lift off the substance with the point of the small instrument sold for the purpose, and known as the "corneal spud." A piece of damp cotton wool, twisted to a point, may also be employed for the purpose, in the absence of a more formal instrument. A very remarkable case was reported by William Mackenzie in his 'Practical Treatise on the Diseases of the Eye' (fourth edition, 1854, p. 231). A child was brought suffering from severe inflammation of one eye, accompanied by a puriform secretion. From under the edge of the upper lid there projected a black, roundish body, which, at first view, even so acute an observer as Mackenzie thought might be a protrusion of the part of the iris through an ulcer of the cornea. His surprise was great when, on cautiously raising the upper eyelid, he found this was a case not of figurative but of real myocephalon. A common house fly had been firmly lodged for eight days between the eyeball and the upper eyelid, its head projecting in such a way as to produce the appearance described.

Foreign bodies, as already said, may lodge in the sulcus that lies above the upper eyelid, the superior *cul-de-sac*, and in that position they give rise to little discomfort and may readily be overlooked. In the latter event the most anomalous appearances may be met with,

particularly when the substance has been present for several weeks or months. A child, aged 5 years, presented a red and fleshy mass, as big as a pea-nut, growing out of the eye, and springing from the outer end of the upper conjunctival sac. Under an anæsthetic I snipped away the growth, and found at its point of origin from the conjunctiva a bit of straw, nearly half an inch in length. I have met with several similar cases, without exception in young children. Dr. Deschamps, of Grenoble, has recently pointed out* that in practically every case of so-called polypus of the conjunctiva that has fallen under his notice a small embedded foreign body has been the cause of the mischief. While it is true that in most cases these polypi originate from the superior *cul-de-sac*, yet I recently met with a case where such a growth was situated in the ocular conjunctiva, 6 mm. or so from the edge of the cornea. The appearance presented was that of a fleshy mass, the diameter of which measured 4 mm. It was removed, and a little piece of bristle from a bass broom found to lie at its root.

A foreign body, usually an eyelash, may lodge in the upper or lower punctum lacrymale, a position where it may lead to considerable irritation of the eye. For my own part, I have twice removed cilia from the lower punctum. At the Ophthalmic School it was not an uncommon event to remove short hairs from the puncta of boys a day or two after the barber had visited the institution. Certainly, in my experience, foreign bodies in the puncta are not so rare as current statements might lead one to think.

Cornea.—A slight injury of the cornea, such as is inflicted by a foreign body, is in elderly persons with unsound tear-passages the common cause of one of the most destructive forms of corneal ulceration, the so-called ulcus serpens or hypopyon-keratitis. We distinguish between foreign substances embedded superficially and deeply in the cornea. The former, much the more common, should be removed as soon as they are found, the eye having first been rendered insensitive by a few drops of cocaine, 2 per cent., and adrenalin hydrochloride, 1: 1000. In very young children a general anæsthetic, however, will almost certainly be required. The substance is taken away with the corneal spud or by means of the twisted wool mentioned before.

It is with deeply-embedded bodies, however, that mistakes in diagnosis and treatment are likely to arise in children. A rule might be formulated, namely, that whenever you come across in a child a lesion of the cornea that does not resemble any ordinary

* 'Annales d'Oculistique,' 1903, i, p. 429.

speck, infiltration, or ulcer, suspect the existence of a foreign body, and do not allow the patient to leave without satisfying yourself as to the truth or falsity of that view. A few weeks ago, a child of $2\frac{3}{4}$ years was brought to me with the statement that a speck had been noticed on one eye for several days. Upon examination, I found a greyish, semilunar figure at the centre of the cornea. It resembled no lesion that I was familiar with. Under ethyl chloride, I removed a paring from a child's nail, which was rather deeply embedded in the substance of the cornea. On the 18th of February last a small boy, aged 4 years, was brought to me at the North-Eastern Hospital for Children on account of a speck, which had been noticed for about a week, on the right eye. The eye was red, and showed a degree of photophobia. In the lower inner segment of the cornea lay a yellowish humped mass, presenting a curiously dry appearance. It was surrounded by a distinct groove in the tissue of the cornea. The mass extended from the limbus 4 mm. into the tissue of the cornea. Under ethyl chloride, it was readily detached with the aid of a cataract needle, when it proved to be a seed-husk. I have had somewhat similar experiences with the operculum of the periwinkle, elytra of certain insects, and other singular foreign bodies.

The following case, which represents another kind of injury calling for different treatment, fell under my notice not long ago. A girl, aged $5\frac{1}{2}$ years, had suffered from an inflammation of one eye, without known cause, for some days. Upon examination, I recognised a greyish line in the depths of the upper-inner part of the cornea as being an embedded splinter of wood. The patient was admitted into hospital, an anæsthetic was given, and an incision was made close to either side of the splinter, not a vestige of which projected above the surface of the cornea. I was unable to seize with fine forceps any bit of the foreign body. Accordingly, with a cataract knife I made a radial incision close to the intruding substance through the entire thickness of the cornea, of course opening the anterior chamber and letting the aqueous humour escape in doing so, and in that way seized and withdrew the body, which proved to be a sharp splinter of wood, just one eighth of an inch in length. The eye made a good recovery, without any entanglement of the iris in the corneal cicatrix.

A still more awkward accident is for a foreign body to be so deeply embedded in the cornea that there is a risk of pushing it into the anterior chamber during attempted removal. Under such rare circumstances it is customary to insert a broad needle into the

anterior chamber so as to support the substance whilst the latter is seized from the front and pulled out.*

The lodgment of foreign bodies, especially metallic particles, in the eyeball itself opens up a large and interesting chapter in ophthalmic work. Into that, however, I do not intend to enter here. I would merely say that many eyes, formerly doomed to destruction by reason of such accident, are now saved by the universal employment of the X-rays to localise the particle and of the electro-magnet to remove it. That is one of the most satisfactory pages of preventive medicine that can be found in modern text-books of ophthalmology. Neither do I purpose to discuss the extraordinary tolerance often shown by the orbit even to large foreign bodies, as hat pegs, and so forth.

One word in conclusion. After removing a foreign body from the cornea, never omit to render the parts as aseptic as may be and to keep the eye tied up until such time as the corneal epithelium is regenerated. Moreover, bear in mind that a polypus of the conjunctiva almost invariably denotes a foreign body, and that out-of-the-way corneal changes are not infrequently due to the same cause.

FRACTURE OF THE FEMUR IN A HÆMOPHILIC.

By Keith Monsarrat, M.B., C.M.Edin., F.R.C.S.,
Surgeon, Northern Hospital; Assistant Surgeon, Children's Infirmary, Liverpool.

A boy, aged 8 years, was admitted under my care into the David Lewis Northern Hospital, Liverpool, on February the 11th, 1904. Shortly before admission he had been knocked down by another boy while playing in the street. Examination showed that he had sustained a fracture of the left femur, about the centre of the shaft, oblique from behind, forwards, and downwards—as shown by the radioscopic screen, and with an inch shortening. Under an anæsthetic the deformity was corrected and local splints with a "long Liston" were applied to the limb. During the next few days there was much swelling at the fracture site, and the boy complained of pain which kept him awake at night. On the 18th, a week after the accident, the local effusion showed no signs of disappearing, but rather a steady increase; the apparatus was changed, extension tapes were applied, the local splints were retained, and the limb was

* For a good example by the late Mr. Frank H. Hodges, of Leicester, see 'Ophthalmic Review,' vol. ii, 1883, p. 133.

elevated to a right angle with the body axis and the extension apparatus fixed to a scaffolding over the bed. On February the 21st, three days later, it was noted that no local improvement had taken place and that the temperature had been steadily ascending by evening rises, partly sustained, up to 102° F. on this day. The local swelling was at this time definitely fluid in character, and taken in conjunction with the fever, and the great pain and tenderness of which the boy complained, it was thought probable that we had to do with a secondary inflammatory process. The chart shows that the pulse rate associated itself with the temperature, and on this day, the 21st, was 140 in the morning, 136 in the evening. When counting the pulse in the left wrist, a discoloration which appeared to be a bruise was noticed over the radial artery, and on further examination other "bruises" were found in different parts of the body.

The next day the mother was interviewed, and we obtained the following history: The boy had had diphtheria when eight months old, and this was accompanied by hæmorrhage from the nose and mouth. Subsequently it was noticed that he bruised very easily. He had had a tooth extracted shortly before his accident and bled for a week afterwards, in spite of firm plugging. During the last two or three years he had frequently had swelling in one or other knee: he would go to bed quite well and wake up in the night with pain and swelling in the joint; the last attack occurred one month before admission into hospital. There was no history of a similar affection in any near relative. The mother had had three brothers; one died from "blood-poisoning" following a stab, one died from an unknown cause, the third was alive and quite healthy; the maternal uncles had also been free from any such complaint, nor did the father's family history show any hæmophilic taint.

During the remainder of the boy's stay in the hospital the diagnosis of hæmophilia was fully confirmed; bruises appeared wherever splint pressure was exerted; for example, a Thomas' knee splint which was put on on March the 11th caused considerable effusion in the region of the groin when he was allowed to sit up; the appearance of the bruise from the pressure of the nurse's finger in taking the pulse shows in what a pronounced form the affection existed. Lastly, on April the 28th the left knee developed all the signs of a characteristic hæmophilic joint.

Union at the seat of fracture occurred satisfactorily and was not at all delayed; on the contrary, consolidation took place somewhat earlier than usual; four weeks after the accident it was firm, and measurement showed absence of any shortening.

I have thought it worth while to record this case because of the absence in the text-books of reference to the influence of hæmophilia on fractures. The points of importance seem to be :

1. The local sign, the occurrence of an enormous effusion of blood around the fracture site and the association of this with other local and constitutional signs suggesting the inflammatory nature of the effusion.

2. The fact that union took place satisfactorily and early.

The boy is at present under treatment as an out-patient for a recurrence of the effusion into the left knee. The fever which the chart shows must be looked upon as an exaggeration of the "traumatic" fever which the great majority of cases of simple fracture exhibit. The absorption of the effusion was not associated with the presence of any unusual constituent in the urine.

TWO CASES OF PTOMAINE POISONING.

By Charles Mackey, M.B., Ch.B.,

Senior Resident Medical Officer of the Manchester Children's Hospital, Pendlebury.

(By the kind permission of Dr. Henry Ashby and Dr. H. R. Hutton, physicians to the above hospital, I am able to publish the following notes.)

Case 1.—F. C—, female, aged 6 years; admitted into hospital on April the 8th, 1904, with abdominal pain, vomiting, and diarrhœa.

Nothing important in family history or previous health of patient.

History of present illness.—Patient was quite well up to April the 4th, on which day she had been at a fair and partaken of a large quantity of ice-cream obtained from stalls there. On April the 5th she complained of abdominal pain, vomited two or three times (character of vomit not known), and had diarrhœa-stools, said to have been of a bright yellow colour at first, passing on to olive-green later, and of watery consistence. Diarrhœa and vomiting continued, and there were cramps in the legs and face. These symptoms, along with marked thirst, continued up to the time of admission.

Condition on admission.—She was a well-nourished child with marked facies hippocratica, drowsy and restless. Temperature, 98·2° F. Pulse 144, feeble and irregular.

Respiratory system.—There was a slight cough. In the left scapular region a few friction-sounds and fine crepitations were heard.

Alimentary system.—The child constantly asked for cold water and pointed to the right iliac region as being the most painful area.

The tongue showed a brownish fur, and the legs were flexed at the hips and knees. The abdominal wall was firm, tender, and retracted. There was a small nodular swelling at McBurney's spot.

Other systems were apparently normal.

Treatment.—Milk diet. Brandy ʒijs. every twenty-four hours.

℞

Spiritus ammoniæ aromaticæ. . . .	♏v.
Tincturæ Nucis Vomicæ	♏iv.
Syrupii Pruni Virginianæ	♏xx.
Aquæ ad	ʒii.

Quartâ quâque horâ sumendus.

Progress of case.—April the 8th, 1904, 8 p.m. Temperature 97·4° F. Patient was restless and delirious, and vomiting continued. Milk diet was discontinued and small quantities of the following were given: Valentine's meat juice, Brand's essence, and milk with soda-water. The nodule in the iliac fossa was no longer felt.

April the 9th.—The patient's condition seemed very little changed. The mixture of the previous day was discontinued and acetozone, gr. ii every fourth hour, was substituted. Two drachms of liquor strychninæ were injected subcutaneously every fourth hour. Suppositories and nutrient enemata were ordered after irrigation of the lower bowel. Diarrhœa and vomiting ceased.

April the 10th.—Patient much worse; coma now complete; the eyes more sunken, face more pinched in appearance. She retained small quantities of peptonized milk given at frequent intervals. Nasal feeding resorted to.

April the 11th, 2 a.m.—Radial pulse could not be felt. Fifteen minims of ether were injected subcutaneously. An attempt was made to transfuse normal saline solution into the right median cephalic vein; but the fluid would not run. Death occurred at 5 a.m.

April the 13th.—*Autopsy*: *Brain,* medulla oblongata and membranes normal. *Heart, kidneys, spleen, pancreas,* normal in appearance. *Alimentary canal*: the serous coat of the stomach and intestines was of a pinkish colour and the vessels appeared to be very prominent. The mucous membrane was very œdematous and hyperæmic. Injection of the blood-vessels was well marked in the lower part of the ileum, in isolated patches of the jejunum, and in the iliac colon. The cæcum and vermiform appendix were normal in appearance. Peyer's patches and solitary glands were not particularly affected and were not prominent. No ulcerated surface was found.

The mesenteric glands were somewhat enlarged and appeared very congested on section. The intestines contained yellowish, viscid, sour-smelling fluid, but no solid contents. *Lungs.*—There was a small patch in the left lung, where the bronchi contained a little purulent secretion

Case 2.—A. C—, a female, aged $5\frac{1}{12}$th years, was admitted into hospital on April the 27th, 1904, for vomiting and diarrhœa.

Nothing of consequence had occurred in the family history or previous health of the patient.

History of present illness.—On April the 23rd, 1904, the child complained of headache and had vomiting and diarrhœa—pale yellow offensive stools being passed. She had been "Maying" for eight hours, and so had not been under observation with regard to what she had taken to eat.

Condition on admission.—Patient was a pale, well-nourished child with face of an ashen tinge and "abdominal" expression; she complained of thirst. Pulse very weak, 156 to the minute. Temperature 97·2° F. She was very restless.

Alimentary system.—The tongue showed a brownish fur. The abdomen was slightly retracted and apparently painless on palpation. No enlargement of the liver or spleen could be made out, and nothing abnormal was found on palpation.

Cardio-vascular system.—The pulse was very weak and "running" 156 per minute; heart beating in embryonic fashion, but no adventitious sounds audible.

Respiratory system.—Normal.

Treatment.—Diet: small quantities of lime-water, barley-water, Benger's food, Valentine's meat juice, Brand's essence, plasmon, veal tea, and brandy, were ordered.

℞

Calomelanos	gr. i.
Sacchari albi	gr. iii.

Misce fiat pulvis statim sumendus.

℞

Bismuthi salicylatis . . .	gr. vi.
Emulsionis petrolii . . .	℥xx.
Tincturæ belladonnæ . . .	℥ijs.
Aquæ laurocerasi	℥xx.
Aquæ chloroformi ad . . .	ʒii.

Quartâ quâque horâ sumendus.

℞

Injectionis hypodermicæ liquoris
strychninæ . . . . ♏iii.
Quartâ quâque horâ sumendus.

℞

Injectionis hypodermicæ morphinæ
hydrochloratis. . . . ♏ii statim (11.30 p.m.).

Progress of case.—April the 28th. The patient appeared worse, unconscious, and very restless. She took a fair amount of food; vomited twice; the bowels acted once during night, but not since the calomel was taken; had peculiar moaning expiration.

Examination of blood.—Red corpuscles, 6,250,000 per cmm.; white corpuscles, 11,240 per cmm.; hæmoglobin, 88 per cent.; colour index, 0·70.

Anuria since 4 p.m., April the 27th.

℞

Magnesii sulphatis	gr. xxx.
Sodii sulphatis	gr. x.
Glycerini	ʒjs.
Aquæ ad	℥js.

Misce fiat Haustus statim sumendus.

The lower bowel was irrigated with normal saline solution.

6.30 p.m.—Still no urine passed and no distension of bladder apparent. Normal saline solution ℥xvi transfused into the right median cephalic vein, volume of pulse thereby greatly increased.

9 p.m.—Had repeated desire to urinate, but still none passed; restlessness very marked; no convulsions.

10 p.m.—Passed ℥viii urine—sp. gr. 1008; a trace of albumin; no blood.

Chloretone gr. vii were administered.

April the 29th, 4 a.m.—Urine ℥xvi passed. Patient appeared much better. She was quite conscious. Pulse 148 to the minute, of good tension and volume.

April the 30th.—Recovery from this date was uninterrupted.

May the 5th.—Examination of blood. Red corpuscles, 4,230,000 per cmm.; white corpuscles, 18,100 per cmm.; hæmoglobin, 86 per cent.; colour index, 1·01.

May the 13th.—Patient discharged from hospital, apparently in very good health.

Since writing the above notes a third case presenting similar conditions to those of the foregoing has been treated at this hospital.

VALVULAR OBSTRUCTION IN THE URETHRA OF AN INFANT, WITH SECONDARY CHANGES IN THE URINARY ORGANS.*

By C. A. Morton, F.R.C.S.,

Professor of Surgery, University College, Bristol; Surgeon Bristol General Hospital and Bristol Royal Hospital for Sick Children and Women.

Although there are many specimens in museums of conditions somewhat resembling the one present in this case, clinical records of such cases seem to be rare. There is also one very important fact illustrated by this case, *i.e.* that the obstruction being valvular, with the valve sloping towards the bladder, a very serious obstacle may be present to the passage of urine, and yet a catheter may enter the bladder without the slightest difficulty.

A baby aged 13 months was sent to me at the Children's Hospital with a history of three months' wasting and vomiting, and a distended abdomen. This distension was mainly due to flatulence associated with hard scybalous masses, but a central hypogastric swelling suggesting a distended bladder was also present. The infant passed urine in apparently natural quantity, however, and I did not pass a catheter for a day or two after admission. When I did so I used a Jacques No. 3, and this entered the bladder quite easily, and withdrew several ounces of urine, and caused the hypogastric swelling to disappear. Blood and pus were noticed in the urine during the next twenty-four hours, and the temperature rose considerably. The temperature had been 101° F. and 102° F. after admission before the catheter was passed, and probably pus had also been present in the urine at that time, though I have no note of it. A large fæcal mass had to be cleared out of the rectum, and also scybala higher in the bowel were removed with enemata. The infant died a week after admission. The catheter passed was boiled, and every precaution taken to prevent infection by its means, and I think there is no doubt that cystitis and pyelitis were present at the time it was used.

At the post mortem a dilated and greatly hypertrophied bladder was found; the ureters were so dilated as to resemble small intestine; and both kidneys were much enlarged from hydronephrosis, but a considerable amount of renal tissue remained. The mucous membrane of the bladder was plum coloured from hæmorrhage, and

* Read at the Provincial Meeting, Bristol, June the 18th, 1904.

had exudation of lymph on it: hæmorrhages were also present in the mucous membrane of the pelvis of each kidney, which contained purulent urine. A small valve-fold was found in the roof of the urethra just beyond the vesical orifice, directed downwards and backwards, so that although the passage of urine would be much interfered with, a catheter would not be obstructed.

Clinical Memoranda.

A CASE OF CHRONIC GRAVES' DISEASE.*

By E. Cecil Williams, B.A., M.B.Cantab.,

Physician in charge of Out-patients, Bristol Royal Hospital for Sick Children and Women.

About eight months ago the mother noticed the child, a girl aged 12 years, was not well, and her eyes seemed more prominent. When seen five months ago at the Children's Hospital, she complained of shortness of breath on exertion. There was some prominence of the eyes. Graefe's sign not present. There was no enlargement of the thyroid gland. Pulse 160 to the minute. Slight muscular tremor. Care should always be exercised when recommending even slight operations in these patients, as it is possible to convert them into acute cases, with fatal results. A case bearing on this point was reported by me in the 'London Hospital Gazette,' May, 1903.

DUODENAL ULCER IN A CHILD FORTY-FOUR HOURS OLD.*

By H. W. Kendall, F.R.C.S.,

Surgeon to the Bristol Royal Hospital for Sick Children and Women.

The child was born quite healthy and of good weight. Twenty-seven hours after birth it vomited a quantity of blood, and at the same time passed blood *per anum*. It passed a little more blood a

* Exhibited at the Provincial Meeting, Bristol, June the 18th, 1904.

few hours afterwards, and was very weak. Thirty-six hours after the first vomiting it passed more blood, and died from hæmorrhage.

The mother was very healthy. The father's state of health was unknown. The child was illegitimate.

CASES OF CONGENITAL DEFORMITIES.*

By H. Elwin Harris, B.A., M.B.Cantab., F.R.C.S.,

Surgeon to Out-patients and Surgeon in charge of the Throat, Nose, and Ear Department of the Bristol Royal Hospital for Sick Children and Women.

Case 1. *Congenital absence of the left ear with facial paralysis.*—In this case there is no trace whatever of an ear upon the left side: the only change from the smooth skin in that region is a small papule, cartilaginous to the touch, with a small depression in its centre. There is and has been from birth well-marked facial paralysis.

The soft palate is distorted, the affected side being broader and higher than the other side.

Case 2. *Congenital absence of the right external ear, excepting a partial development of the auricle.*—There is apparently some sense of hearing on that side.

In the first two or three months of her pregnancy the mother was visited by a minister who was affected in the same way.

Case 3. *Intra-uterine amputation of three extremities; webbed fingers on the hand of the only limb.*—Both legs are absent from $1\frac{1}{2}$ inches below the hip-joint, and the left arm is removed flush with the shoulder-joint. The fingers of the remaining hand are webbed together to their tips. On the right stump is a fanciful resemblance to a very minute leg. One could trace the knee-joint, ankle, and an attempt at a foot. He did not think that any satisfactory explanation had been given of those deformities. The idea of amniotic adhesions was, he thought, insufficient to explain them.

* Exhibited at the Provincial Meeting, Bristol, June the 18th, 1904.

A CASE OF CURED HYDROCEPHALUS.*

By J. Michell Clarke, M.A., M.D.Cantab., F.R.C.P.,
Physician and Pathologist to the Bristol General Hospital.

Dr. Michell Clarke showed a case of hydrocephalus in which recovery had occurred. The case came under observation at the age of eight months, and the first symptoms probably appeared at about six months. The condition in the following three or four years was very marked, the child being unable to sit up or stand. Intelligence was always very good. After this it slowly began to recover power in the limbs, and the head ceased to increase in size. Improvement had gone so far that twelve months ago suitable iron supports were fitted to the legs, and since then there has been a steady recovery of power. There are signs of partial degeneration of the pyramidal tracts in rigidity, and exaggeration of reflexes The head measures now nearly 23 inches in circumference. The treatment was by small doses of Hydrargyrum ō Cretâ, continued over long periods. The case was shown on account of the rarity of recovery from such a condition.

The Society for the Study of Disease in Children.

An Ordinary Meeting of this Society was held at No. 11, Chandos Street, Cavendish Square, London, W., on Friday, October the 21st, 1904, Dr. Fletcher Beach being in the chair.

The Chairman (Dr. Fletcher Beach) announced that he had received an advanced copy of the fourth volume of the 'Reports,' which would in due course reach each member. It was very satisfactory, and the Editor had worked harder than ever upon it. The volume was larger than previously. He also announced that a special meeting would be held in December for the purpose of discussing the question of "Sudden Death in Children."

A Boy with Hypertrophy of the Leg was shown by Dr. C. O. Hawthorne. The right lower limb was hypertrophied below the knee. The condition was associated with dilatation of the blood-vessels, and during the last twelve months had been attended with an obstinate process of ulceration on the front of the leg. The bulk and weight of the limb caused the boy much inconvenience, and it had been suggested that the leg should be amputated.

* Exhibited at the Provincial Meeting, Bristol, June the 18th, 1904.

That was the practical point on which he would be glad to have the opinion of the Society.

Mr. Arthur Edmunds said the interest of the case seemed to depend upon the nævoid condition, and the hyperplasia was probably secondary to some increase in the vascularity of the part. He thought the papillary growths around the ulcer were due to inflammatory blocking of the lymphatics in that region. Although he believed that for ulcer of the leg amputation was too rarely performed, yet in the present case he thought the boy was too young for such a drastic measure, and the loss of a limb always greatly militated against obtaining employment. If the patient were placed under better hygienic conditions, in a hospital or some clean place, with his leg elevated, and at rest, the ulcer would probably heal. He advocated a prolonged trial of hospital treatment before amputation.

A Case of Habit Spasm was shown by Dr. Robert Hutchison. The boy was ten years old. The spasm involved chiefly the muscles of the right side of the neck, but there were occasional blinking movements of the eyes also, and sometimes violent flexion of the whole head. The spasm had lasted for two years and was of unknown causation. There was no history of chorea. Another boy at the same school was said to have developed a similar spasm from "mocking" the patient. Suggestions for treatment were invited. In reply to the Chairman, he said that there was no question of imitation. Some one had suggested to him that the case might be treated by hypnotism, and he would be glad to hear the opinions of members on that point. He had tried ordinary moral suasion and suggestion, which for a time seemed to do good, but recently the condition had become worse.

Dr. Leonard Guthrie doubted whether the case was one of pure habit-spasm, because it had lasted so long. One was familiar with the tricks of neurotic children, but with them one trick frequently gave way to another; at one time a child would do its utmost to screw its mouth round its nose, and at another there would be a different facial spasm. Dr. Hutchison's case might probably be due to some organic disease. He had seen a case, which was not his own, of spasmodic torticollis of very many months' standing, and which was benefited by the application of galvanism to one side and faradism to the opposite side.

Dr. G. A. Sutherland said he had nothing to suggest in the way of treatment, but he had read in one of Dr. Cheadle's writings that in cases of habit spasm coming on between the ages of ten and fourteen years it passed off on the completion of the second dentition. Dr. Cheadle did not recommend any treatment, and his (Dr. Sutherland's) experience had agreed with that; the condition had always passed off in his cases.

Dr. Porter Parkinson said he had seen that day a man aged sixty-five years, who had had a peculiar spasm of the left eyelid and the left side of the face ever since he was five years of age. The only muscles affected appeared to be the orbicularis oculi on one side, and some small muscles of the left side of the face. The spasm was considerably aggravated when the man became excited. He expressed no opinion as to whether the present was a case of habit spasm. He had an acquaintance, a gentleman over seventy, who had always had a similar affection, chiefly involving the muscles, which drew the mouth to one side, and accompanied by a pressing of the tongue into the cheek. In neither case had there been any cerebral or other symptoms. Thus there were certainly some cases, apparently indistinguishable from those of habit spasm, in which the spasm certainly did not pass off.

Mr. C. H. Milburn (Hull) had suggested to Dr. Hutchison the use of hypnotism in the case because he had been told that treatment had been of no avail, and his suggestion was in the nature of a last resource. In course of conversation with the boy's mother, he asked her if there were twitchings or movements of the feet. She replied that she had not noticed any; but immediately the question was asked the boy shuffled his feet. After an interval, he asked the mother if there had been movements of the hands. She replied that none had been noticed, but in response to this question the boy twitched both hands. After another interval, he asked the mother whether there had been movements of the shoulders. She replied that she had not noticed any, but immediately the boy twitched both shoulders. That seemed to show that suggestion had an influence in producing the movements, therefore probably a counteracting suggestion might have a good effect.

A Case of Bromide Rash in an Infant was shown by Dr. Robert Hutchison. It had been treated with bromide of potassium (dose unknown) for fits for about two months. The rash was scattered over the face and outer aspects of the arms and back, and consisted of the peculiar discrete, fleshy spots which are common in bromide rashes in young children.

Dr. Parkes Weber asked whether the kidneys were abnormal in the case, because he believed that in people who developed a bromide rash the eruption had a tendency to take a mycotic form, if there was disease in the kidneys which had been overlooked when the drug was given.

Dr. Robert Hutchison, in reply, said there was no reason to suppose that the patient had renal disease, but no examination of urine had been made to ascertain that. He would look into the matter.

Two Sisters with Congenital Hereditary Trophic Œdema were shown by Dr. O. F. F. Grünbaum.*

The Chairman (Dr. Fletcher Beach) said he was not surprised at the reason given by the mother in the case, because after a long experience in examining histories of that kind he had found that all mothers did their best to give an explanation of any abnormality present in their children, and they were anxious to account for anything wrong by an explanation that it must have occurred after birth, feeling that a stigma attached to them if it occurred before birth.

Dr. Parkes Weber mentioned that there was an almost identical œdema, not congenital, and certainly not of a family character, which came on at any time of life, and led to a thickening without the disagreeable roughness which was found in ordinary elephantiasis. It might be answered that the cases which occurred considerably after birth were of a different class, but he did not think there was evidence of that; they looked the same, developed similarly, and were chronic, localised, trophic œdemas. The cases might be either bilateral or unilateral; in fact, they corresponded practically in every way.

Dr. Porter Parkinson thought the prognosis in these cases was illustrated by the fact that the mother of such a case attended one of the hospitals in London in 1863, with a similar condition of congenital enlargement of the parts of both limbs below the knee. In spite of treatment that

* These cases will be published in full in the next number of the Journal.

enlargement gradually increased, and now both her legs were of considerable size. In the case of her child, two or three months' bandaging of the legs had no effect whatever. The œdema in both the instances was hard, and did not pit on pressure. The possibility of cardiac or renal disease was negatived in the case of the mother by the duration of the condition. There was no sign of such disease in her child.

Mr. George Pernet said that the cases were extremely interesting, because the question of hereditary chronic trophœdema had caused a good deal of discussion. In the younger of the two cases there was certainly hypertrophy of the skin, but he had risen in order to draw attention to a very interesting paper by Meige, in the 'Iconographie de la Salpêtrière.' It contained many illustrations of the disease, in cases where it spread over several generations. Meige mentioned a case recorded by Milroy, in the 'New York Medical Record,' which affected twenty-two individuals, spreading over six generations. According to Meige, treatment in such cases appeared useless. With regard to congenital elephantiasis, which had been dealt with by many dermatologists and others, he would refer to a paper by Moncorvo, of Rio de Janeiro, in which there was a picture of a case something like the one shown at the Bristol meeting of the Society by Drs. Rogers and Fortescue-Brickdale.

Dr. C. O. Hawthorne said that in the paper referred to there was considerable evidence as to a distinct group of cases which could be called chronic, trophic œdema. He had no experience of the disease, but would say that the present cases corresponded with those in the paper. Whether the term "trophic" was justified or not, he thought it necessary to insist upon some specific distinguishing term, because he believed there were cases of œdema which would be simply spoken of as œdema—*i.e.* cases occasionally occurring in young children who displayed no hypertrophy of the skin or other parts, the limb being simply œdematous, the œdema going down when the limbs were raised. He believed a description was given of such cases with illustrations by Dr. Rolleston in one of the medical journals about a year ago.

Dr. Grünbaum (introduced), in reply, said he had looked up the literature on the matter, and it seemed to him there were three definite conditions: one mentioned as segmental œdema, where it was not necessary for the ends of the limbs to be œdematous, and in which he believed it to be due to a segment of the cord being affected, and the nerve supply from that segment being interferred with, and leading to localised œdema. Another form was that to which Dr. Hawthorne had referred. In the case of the two sisters mentioned by Dr. Hawthorne, the œdema developed comparatively late in life, at about sixteen years of age. Dr. Batten had suggested that thyroid might be useful, and he would have liked to have heard whether it had been useful in such cases.

Mr. George Pernet remarked further that Meige pointed out that in his cases, which were rather later ones, thyroid was useless.

A Case of Cerebral Degeneration with Fundal Changes and Incomplete Ophthalmoplegia was shown by Mr. Sydney Stephenson. The boy's optic discs were pallid, and inconspicuous pigmentary changes were noticeable in the central region of each fundus oculi. Central vision was lost. Symptoms had been present for about eighteen months, and were progressing slowly. No evidence of syphilis. No blood-relationship between the lad's parents. Mr. Stephenson believed that the case was analogous to

those described recently by Batten, Still and Gunn, Mayou, Hirschberg, and Hutchison.

In reply to the Chairman (Dr. Fletcher Beach), Mr. Stephenson said the child was at present very dull.

The Chairman said he asked the question because there was a class of cases which had been described as amaurotic idiocy, and he did not know whether the present case was sufficiently dull to be looked upon as an idiot. Some cases had been described by Risien Russell before the Royal Medical and Chirurgical Society with very similar symptoms to those mentioned, and all of them ended fatally. Possibly Mr. Stephenson's case belonged to the same category.

Mr. Bishop Harman (introduced) said he had a number of analogous cases to examine at the County Council Blind Schools. There were a number of cases which were blind from optic atrophy of various kinds, and there were all grades, from the degree of the present case to the grossest. It was difficult to draw a hard and fast line between those and some which would be called disseminated choroiditis. He met with two little girls some time ago who had the condition, who had been seen by a distinguished ophthalmic surgeon, who described it as disseminated choroiditis, and told the father that it was the result of hereditary syphilis. The father denied any possibility of that disease. There was no reason to suspect it having been present. Still, he (Mr. Harman) thought they were syphilitic in character, and were a very fine type of disseminated choroiditis. Whether they should be grouped absolutely alone in a little isolated patch, as Mr. Stephenson had suggested, he was not convinced, because they shaded off so well into those which no one would hesitate to call disseminated choroiditis.

Mr. Stephenson, in reply to the Chairman, said the two cases resembled one another in that they were family affections, but the age of the patients and the character of the ophthalmoscopic changes, and, so far as was known, the termination of the cases, differed. He passed round a picture which was published by Mr. Frederick Batten. It was interesting to hear Mr. Harman's experience, as he devoted some attention to the eyes of children, but he could not agree when he suggested that he (Mr. Stephenson) should attempt to form them into "a little isolated patch" of cases. The cases might shade off into syphilitic choroiditis, but even if they did—and he was not sure about that—he was not aware that syphilitic choroiditis was associated with mental failure and the other symptoms which characterised the patient he had exhibited that evening.

Two Cases of Encephalitis associated with Measles were shown by Dr. Leonard Guthrie and Dr. J. Anderson Smith (introduced).

Case I.—**Cerebral Diplegic Athetosis.** This case, shown by kind permission of Dr. George Ogilvie, was that of a boy aged 6 years, who developed measles in February, 1904. On the sixth day he was seized with general convulsions with unconsciousness. He remained unconscious for seven weeks, speechless, and paralysed on the right side, with complete loss of sphincter control. At present he was rapidly regaining speech, though his utterance was very indistinct. He did not appear to be mentally deficient, and was beginning to control his sphincters. The optic discs were healthy. There was no trace of right hemiplegia, except slight weakness of the lower half of the right face. He was unable to sit or stand, and showed

in a marked degree typical athetosis affecting the trunk and all extremities. The movements were slow, forcible, hyper-extensions, hyper-rotations, flexions, etc., of the limbs opposing and alternating against each other. The fingers were widely separated and slowly flexed or extended alternately in "star-fish-like" actions. A common position of the upper extremities was strong inward rotation, with elbow hyper-extended, wrist flexed, hand pronated with palms looking outwards. Similar movements were observed in the lower extremities. The movements ceased during sleep, and were increased by attempted voluntary actions. The knee-jerks could not be elicited. There was no ankle clonus. The plantar response was usually negative, sometimes extensor.

Case II.—**Polioencephalitis** (cerebellar type) **occurring during Measles.** This child, a girl aged 6 years, had been shown by Dr. Anderson Smith in April, 1904, before the Society. In February of this year, on the third day of an attack of measles, she developed cerebral symptoms—vomiting, eclampsia, followed by strabismus, photophobia, and retraction of head. After five days the acute symptoms subsided, but the patient was aphasic, hyperæsthetic generally, and wasted rapidly. There was no optic neuritis. A month later she was still aphasic. She could not sit up in bed, and moved her limbs in ataxic fashion, and appeared to have general cutaneous anæsthesia. The limbs were slightly rigid, knee-jerks were exaggerated, and ankle clonus was present. Loss of sphincter control persisted for two months. At present the patient was quite intelligent. Speech was restored, but utterance was slow, monotonous, and scanning. Discs were normal. There was slight tremulousness and ataxy of upper extremities, and marked inco-ordination of the lower. She would not stand without support, showing tendency to fall backwards. Staggering was not increased on closure of the eyes. The gait was typical of cerebellar disease. The knee-jerks were exaggerated; ankle clonus was present at times; the plantar response was flexor, but difficult to elicit.

In remarking upon the cases Dr. Guthrie said that both were probably instances of polioencephalitis occurring during measles. In the boy's case some slight degree of congenital spasticity had doubtless been present, and the encephalitis had affected chiefly the cortical or sub-cortical motor areas of the cerebrum. In the girl's case the symptoms pointed to occurrence of cerebellar polioencephalitis. He drew attention to Dr. F. E. Batten's valuable series of cases illustrating the effects of polioencephalitis on different areas of the brain, and their relationship to anterior poliomyelitis ('Lancet,' vol. ii, December the 20th, 1902).

A Case of Infantile Paralysis, with Involvement of the Abdominal Muscles, was shown by Mr. Arthur Edmunds.

Dr. G. A. Sutherland said a point which was of interest from the medical standpoint was the localised bulging under the ribs. If one had not known the history of the case, and it had only just been seen, he thought another possibility would have suggested itself, namely, that it was congenital absence of the muscular wall on that side. When the child was first seen, the whole of that side was paralysed, but under treatment by faradism and galvanism the greater part recovered nine years ago.

A Case of Double Congenital Dislocation of the Crystalline Lenses was shown by Mr. N. Bishop Harman.

A Case of Congenital Cardiac Disease was shown by Dr. Edmund Cautley. The child, aged three years, was of normal size and fair nutrition, but rather anæmic. The cardiac impulse was a trifle exaggerated, but in its natural situation. The cardiac dulness was not increased to the right. A systolic thrill was felt over the second and third left intercostal spaces near the sternum. A systolic murmur was audible all over the præcordium, loudest over the thrill area. It was heard in the great vessels of the neck. Occasionally a short diastolic bruit could be heard in the second and third left intercostal spaces. In addition, the left superior rectus muscle of the eye was paralysed. Dr. Cautley suggested there might be a direct communication between the aorta and pulmonary artery, or possibly patent ductus arteriosus. He could not accept a diagnosis of pulmonary stenosis owing to absence of cyanosis, clubbing, and want of evidence of hypertrophy of the right ventricle. The possibility of a syphilitic origin was considered, as also that of more than one lesion being present.

Dr. C. W. Chapman thought it was impossible to say what the condition was without an autopsy. He considered the practical point was the question between pulmonary stenosis and the lesion which Dr. Cautley had suggested, but he was rather in favour of the former.

A Case of Imbecility with Irregular Movements and Spasticity was shown by Dr. Edmund Cautley. The child was twenty-one months old, the labour was natural, and there was no evidence of congenital syphilis. She had a small head ($17\frac{1}{2}$ inches), was imbecile, dirty in her habits, had rigidity of the limbs, especially the legs, and exaggerated knee-jerks. Irregular jerky muscular movements of the hands and arms, of the trunk and lower limbs, were also seen. He considered it to be a mild case of spastic paraplegia in a microcephalic idiot.

The Chairman (Dr. Fletcher Beach) said he had seen several cases of the kind when he was at Darenth Asylum many years ago—children with small heads with a spastic condition of the limbs, who never practically recovered the use of their extremities; but he had not seen a case in which tremors had been so marked as in the present instance. He was inclined to think it was a case of imbecility associated with a spastic condition of the limbs, and such as was not at all uncommon.

Dr. Porter Parkinson saw from time to time a case of microcephalic idiocy, with considerable frontal depression, and in that case there developed certain nervous phenomena other than purely mental ones; for example, spasticity of the limbs and the rigidity is still present. There was in the case a distinct history of very prolonged labour; the child was born in a state of cyanosis, and it was with very great difficulty revived.

A Photograph of a Case of Trichotillomania was shown by Mr. George Pernet. The patient, a boy aged eleven years, when he first came under observation. The photograph was given to Mr. Pernet by Dr. Raynaud, of Algiers. The boy was in the habit of pulling out the hairs of his head and sucking them for the purpose of sexual gratification.

The Chairman (Dr. Fletcher Beach) said he had seen many cases apparently similar to that in the photograph, and there were a certain number of such children who pulled out their hairs. There were some cases in Darenth Asylum, who pulled out almost every hair, until they were practically bald. He had not previously heard the name now applied to the condition, but the photograph showed the case to be evidently a degenerate.

A Case of Herpes Zoster of the Left Arm extending to the Finger-tips was shown by Dr. GEORGE CARPENTER. The eruption affected an extensive cutaneous area, viz. the front and back of the upper part of the chest, the arm and fore-arm in front and behind, the back of the arm, also the palm of the hand and the little, ring, and middle fingers, with a small patch at the root of the little finger on the back of the hand. The nerve roots affected were the eighth cervical and the upper three dorsal nerves. The child made an uninterrupted recovery and nothing worthy of note occurred in the case.

Mr. GEORGE PERNET said the case was one of great interest, because it was extremely rare to find herpes zoster affecting the fingers, but recently he saw a woman who had several vesicles and one bulla on the sole of the foot, the leg and thigh of whom was affected by herpes zoster.

A Paper on an Ill-developed Upper Lateral Incisor Tooth as a Forerunner of Hare-lip or Cleft Palate* was read by Mr. R. CLEMENT LUCAS.

A Paper on Two Cases of Congenital Diaphragmatic Hernia† was read by Dr. SIDNEY GILFORD.

Editorial.

INFANT MURDERERS.

A FORTNIGHT ago there occurred at New York a tragic accident, which appears to us to deserve more than the transitory consideration it has received. The facts are these: A curly-headed youngster aged two years and a half was the petted darling of his parents until a month ago, when a second arrival appeared on the scene to dispute his sway. After forbearing for a month the partial loss of attention and affection that ensued, he resolved to put an end to a state of affairs which was to him unendurable. Left alone with the baby girl one day, he seized a bronze statuette and battered in her face, causing a fracture of the skull and immediate death. A verdict to this effect was returned by the jury, and it is worthy of notice that the boy—his troubles being over—has regained his customary cheerfulness and exhibits no remorse whatever. Indeed, he constantly expresses gladness that the baby has gone.

Cases of this kind are by no means so rare as a casual newspaper reader is apt to suppose. We can remember the reporting of two

* This paper appears in the present issue of the JOURNAL, pp. 483-9.

† This paper will appear in the December number of the JOURNAL.

or three in the present year. That their occurrence is not limited to our race is revealed by a cursory examination of the foreign newspapers of the past few months. From French sources alone, for instance, we take the following examples. The 'Petit Parisien' for September the 26th reports the case of a boy of nine who lured a little girl of six to the river bank and deliberately pushed her in. She was rescued and the boy was confined to his room for three or four days as a punishment. When, however, the first opportunity for escape occurred, he did precisely the same thing with a baby girl of three, and was seen from a distance enjoying himself by gloating over his drowning victim and repulsing her feeble attempts at regaining the bank. This time he was sentenced to a reformatory, to remain there until the age of sixteen. The 'Intransigeant' describes how two Arab boys, aged ten, engaged in a fight at Tunis; one of them, mad with anger, seized a rifle and shot his adversary dead. 'Le Temps,' September the 11th, mentions the finding of the corpse of a girl of six at Le Havre. At the inquest it was discovered that death was due, not to an accident, but to a boy of eight, who had enticed her to the *digue* and pushed her into the sea. 'L'Aurore' gives an account of a drunken brawl, over some trivial question, between a boy of sixteen and a man of forty-five; the former drew a knife and stabbed the man to the heart. The 'Bonhomme Normand,' August the 26th, reports an incident at Finistére, very similar to the New York one to which we have just referred. A little girl, aged two, being very jealous of her baby brother, four months old, got a large knife and cut his throat with it. The sexes, it will be noticed, were the opposite to those in the New York tragedy.

As regards the motives for the crimes, we see that they fall into quite separate groups, and probably their pathology also does. To begin with, there are the first and last cases of our series, where the deed was due to jealousy pure and simple—the jealousy that is so common, if not constant, an occurrence under the circumstances described. The deed is so pure a reflex to the stimulation that it is difficult to see the necessity for invoking any pathological factor. In these cases the "criminal," aged two, and the victim, aged a couple of months, seem both passive agents in the scheme of things due to the family relations of our complex social arrangements; and the

only source for wonder is that such evil results do not more often accrue. The practical conclusions to be drawn are that fond young mothers should cast an occasional thought to the forsaken first-born, and should remember that when he shows marked antipathy to the babe he is sometimes capable of retaining sufficient of the primeval instincts of mankind to make short shift with the source of his woe. His age, albeit it is called the age of innocence, is no bar to such action; indeed, it is only operative in the reverse direction, inasmuch as it renders him incapable of realising the significance of his deed. Next, we have the cases in which the fury of anger is the impelling cause. The militant passions that lie dormant in our nature vary greatly, both in intensity and in the readiness with which they can be provoked in different individuals; and, seeing how frequently they are the cause of serious crime in grown-up people, it is not strange that now and then we see the same results in children. Some of the cases, no doubt, may be due to impulsive insanity, but there seems no need to call in this process to explain the acts in the majority of instances.

Lastly, we are left with a group of cases far harder to understand. In these the deed seems to be prompted by no motive whatever beyond what may be termed the enjoyment of cruelty, and here the participators must be recognised as departing much farther than in the former groups from the normal standard of mankind. We know that slight defects in mental development are apt to be associated with an attitude towards conventional morality that is called "morally defective." Whether this attitude, due to congenital defects, may be present with no other stigmata is a question that cannot be regarded as settled even yet. Be that as it may, we meet, and not infrequently, with children whose most prominent abnormal feature is such an attitude. It is only with the greatest difficulty that we can induce them to see the inconvenience of deeds that to us are heinous; many such children grow up—and, indeed, form a great part of our criminal classes—simply incapable of realising the wrongness of deeds of cruelty, murder, and similar acts. The orthodox view taken by demagogues is that such children are either over-endowed with original sin or under-endowed with the grace that should enable them to perceive the innate and fundamental wickedness of such pro-

ceedings. Perhaps these children might be also explained on the view that they are the subjects of atavism, that natural selection has not been thorough enough with their ancestors. The result is that their social instinct, that instinct that compels ready obedience to the universal laws of mankind, remains so undeveloped that it needs a more coercive environment than is customary. Certain it is that many children delight in performing cruel acts—maiming kittens, crushing flies, and so on—and that it is very common to find such propensities in the different varieties of imbeciles and idiots. Of the children who present no other abnormal trait, most can be educated to look upon such acts with positive repulsion, but whether the ultimate standard of altruism is as high amongst such children as amongst normal children has not yet been ascertained. We certainly do not agree with the view advanced at a recent meeting of the National Association for the Feeble-Minded—to wit, that such symptoms indicate incipient insanity, for in our experience the prognosis in these cases is usually good, provided there be no other evidence of mental deterioration. All gradations can be traced between slight "naughtinesses," such as a fondness for pulling the cat's tail, and the worst forms of cruelty resulting in such an atrocious deed as that reported in the 'Petit Parisien.' The deductions to be drawn are obvious—namely, that there is far more danger than is popularly supposed in the potentialities of certain naughty children; and that, therefore, greater care should be taken from a prophylactic point of view as regards their relations with other children.

Excerpta Puerilia.

The case of Poor-law children's teeth—the multifarious duties of a general practitioner.—From the report of a meeting of the Dorking Board of Guardians it appears that they expect the workhouse medical officer to stop the children's teeth. We rub our eyes and wonder as we read if we are in the twentieth century. The medical officer recommended some of the children

being sent to a dentist to have their teeth stopped or extracted, a guardian immediately moves that the doctor's recommendation be not entertained, a resolution which is apparently carried *nemine contradicente*, and "the medical officer is requested forthwith to do all that is necessary."

A state of intelligence such as is indicated by this resolution is apparently not uncommon or special to a Board of Guardians, as only a day or two ago the Principal of a high-class Preparatory School, an M.A. of Oxford, did not think it necessary that boys should wash their teeth before going to bed! Penrith is, however, alive to its duties; for the Guardians, on the recommendation of their Medical Officer, have decided to engage the services of a dentist to attend to the teeth of the children in the Workhouse. One member, however, voted against the resolution on the ground that he had had his teeth for eighty years without requiring the attention of a dentist.

It would appear that medical men cannot too often impress upon the British public that children's teeth require the skilled care and attention of a dentist at periodical intervals, and that an important factor in keeping children in good health is the proper conservation of their teeth. Poor-law guardians especially it would seem important to educate up to the fact that general practitioners have not usually had the training, nor do they possess the apparatus, "to do all that is necessary."

We commend to the guardians' perusal a "circular on the care of Poor-law children's teeth" which was issued some eight years ago by the Local Government Board, and that they should act on the advice contained in this circular rather than on the strict interpretation of Poor-law consolidated orders on to which the Chairman of the Dorking Board apparently pinned his faith. Admirable as these orders are if construed in the spirit in which they were framed, they become unmitigated red tape where children are concerned if acted upon in the strict letter.

Canal-boat children.—Mr. Llewellyn, Inspector under the Canal Boats Acts, gives an interesting fact in relation to canal-boat children. As it is sometimes said that there are 60,000 boat people on the inland waterways of England, and that 30,000 children are being brought up without any education whatever, he thinks it right to state that, although it is impossible to gauge the exact number, there are, in his opinion, not more than 400 children of school age in England and Wales who have no other homes than the

boats they live in. He estimates that the number of boats used as dwellings is under 7,000.

Boarding out of pauper children.—During the year 1903-04 the Local Government Board authorised eight new committees for the purpose of finding and superintending homes for orphans or deserted pauper children. Three of these committees were authorised to act only in regard to boarding children within the limits of the union to which they were chargeable. The remaining five were empowered to act in respect of children outside the union liable for their maintenance.

The Reports are given of Miss Mason, Miss Pell, and Miss Evans, inspectors of children boarded out beyond the limits of the unions to which they are chargeable, with reference to the working of the system and the children inspected by them. The responsibility for the care of the children boarded out rests entirely with the boarding out committees. The inspections of the children are for the purpose of ascertaining how the duties of the committees are discharged, and cannot be regarded as in any way relieving the committees of their responsibility.

Miss Mason, the senior inspector, states that her experience confirms that of former years—that the boarding out system is either the best or worst according to the manner in which it is administered, and that it continues to improve in the district she visits. The system has not extended as might be desired on account of the insufficiency of good committees, homes, and foster-parents. The main reason why committees do not multiply more rapidly are—the absence of any agency to find, start, or enlist them, the necessity for the advance by the committee of a part of the payments to the foster-parents, and the complaint that the present rate of remuneration to foster-parents (4s. a week and £2 a year for clothing) is insufficient.

Other reasons are the trouble and difficulty of finding employment for the children when of age for service, and keeping them employed, and the insufficiency of cottage accommodation in the country. The children boarded out within the union have increased considerably, and have filled up a large proportion of the homes which might have been available for boarding out children beyond the union.

Boarding out within the union is, in a great measure, only a form of outdoor relief, and it appears to have increased with the recent general increase of pauperism (in actual number, not in relation to population). It is a system (says Miss Mason) which extends

automatically ; for many persons who might maintain children related to them, but for whom they are not legally responsible, will not do so if they see that their neighbours receive parish pay for children under similar circumstances. Also, though there are now about 107 committees within the union for which they act, there is no official inspection to report on and help their work ; while the rest of the children are only under the supervision of the relieving and medical officers, who cannot make that thorough inspection of the homes and bodily condition of the children which a woman can. It is therefore probable that many of the homes are accepted in ignorance of what the treatment of the children really is, and that many of the foster-parents would decline to receive them at the low rates of payment often given if official investigation were made into the nature of that treatment and their expenditure of those payments.

The number of children permanently boarded out by voluntary agencies has not to any appreciable extent filled up homes where children might have been boarded out beyond the union. But the boarding out of the various "country holiday" agencies has increased so enormously of late years that it has distinctly limited the field. These agencies now send children to the country, not only from London, but from most of the large provincial towns. It would be interesting, but impossible, to ascertain how many thousands are sent out in one year, for much of this kind of boarding out is carried on by charitable individuals as well as by societies. The children are sent out for a fortnight each, and usually to the same houses in succession during the whole of the summer. The cottagers prefer them to permanent Poor Law children for many reasons: (1) 5s. a week per child is paid for maintenance alone—the cottagers have not to provide their clothing ; (2) each child remains only for a short time, and is very little tie, responsibility, or trouble, since the very object of sending them out is to let them run free in the country air, and in the summer only. They are mere lodgers, and no "undertaking" is required of the cottagers as to their treatment or training. (3) Nor do all the agencies enforce rules as to overcrowding, or the numbers to be placed together. Not long ago four sleeping in a row were found in one bed, in a house where a Poor Law child was boarded out.

Abstracts from Current Literature.

Medicine.

Epidemic of infantile paralysis (*'La Pediat.,' June,* 1904).—**E. Lorenzelli** describes an epidemic at the Children's Hospital at Parma during the first half of 1903, when twenty-six cases occurred, while in the corresponding periods of 1901 and 1902 only three and seven cases occurred. The cases all came from a limited but healthy area, partly rural and partly urban. The ages of the children were—from birth to 6 months, one case; from 6 to 12 months, four cases; from 1 to 2 years, nine cases; from 2 to 3 years, three cases; from 3 to 4 years, six cases; from 4 to 5 years, two cases; and at 8 years, one case—the majority of cases thus occurring about the second year and in the warmest month of the year. No hereditary influence could be traced either in nervous affections, gout, or tuberculosis; no relation was observed with dentition. In only one case, that of a child bathed in cold water while perspiring, was any connection with cold ascertained. With regard to its relation to gonorrhœa brought into prominence by Hayem, Parmentier, and Dufour, none such was discovered. In only seven cases was any co-existing malady noticed, such as gastro-enteritis, worms, etc.; the other nineteen had been and were perfectly healthy. The initial fever was—in one case, 1 night only; in seven cases, 2 days; in five cases, 3 days; in three cases, 4 days; in two cases, 5 days; in the remaining eight it was not possible to gauge the duration of the fever, but it was not longer than 38 days. In all cases but one paralysis was noticed on the cessation of the fever. Initial disorders of digestion were infrequent and insignificant; vomiting was observed in only four cases, diarrhœa in three cases, and constipation in three cases. Of other symptoms, pains in the limbs (frequent in adult poliomyelitis) existed in five cases, always in those limbs subsequently paralysed; neck rigidity, which, according to Gowers, depends on a slight meningitis in relation with the medullary affection, only existed in one case; cutaneous anæsthesia, either dependent on an unusual diffusion of the process to the sensitive area of the cord or to lowered temperature and deficient circulation and nutrition of the paralysed part, was noticed only in one case, and profuse general sweating in one case. It is noteworthy that in no cases were convulsions noticed as an initial symptom, since it is generally admitted that they are a frequent phenomenon.

VINCENT DICKINSON.

Myokynia in acute polioencephalomyelitis (*'Société de Neuropathologie de Moscow,' February* 21, 1903; *'Arch. de Neurologie,' vol.* XVIII, *No.* 104, *p.* 170).—**N. Delektorsky** describes the case of a boy of fifteen, who, in June, 1902, had a feverish illness for a few days, which left him paralysed in all four limbs. Later the movements came back, except in the upper part of the trunk on both sides and in the right arm, where an atrophic paralysis remained. During this improvement involuntary muscular twitchings appeared, as did paralysis of the lower and middle parts of the right facial nerve, and partial nerve deafness on the right side. He came to hospital six months after the onset, and then showed the above phenomenona. In addition, the deep reflexes were increased in both legs and the left arm;

there was no sensory affection. Complete reaction of degeneration was present in the biceps, deltoid, and brachialis on the right side, with marked diminution of excitability in the other muscles. The twitchings in the neck, tongue, and face were very rapid and incessant; from time to time also appeared tetanic spasms of isolated fibres lasting for some seconds. In the other muscles the twitchings were slower, spread from one muscle bundle to another, and invaded the whole muscle. In the thighs ordinary fibrillary tremors were present. The movements continued during sleep. The twitchings conform to the description of myokyina given by Schultze, and Delektorsky thinks that they depend on an irritation of the anterior horn-cells.

A. Ernest Jones.

Case of progressive myopathy with sensory changes (*'Nouvelle Iconographie de la Salpêtrière,' No.* 2, 1903.)—**Laimon** and **Porot** describe such a case, the only one in the family. The onset was at the age of ten, with lancinating pains and paresis, leading later to generalised atrophy, with pseudo-hypertrophy in the lower limbs, abolition of tendon reflexes, and electrical excitability. There was cutaneous hyperæsthesia, which seems to put the case into the "mixed" group of myopathies.

A. Ernest Jones.

Tibial deformity in congenital tabes (*'Nouvelle Iconographie de la Salpêtrière,'* 1903; *'Arch. de Neurologie,' July,* 1904, *p.* 57).—**Sabrazès** reports a case of tabes due to hereditary syphilis, with an enormous deformity of the tibia like to a sword's scabbard. It is the first such case to be recorded.

A. Ernest Jones.

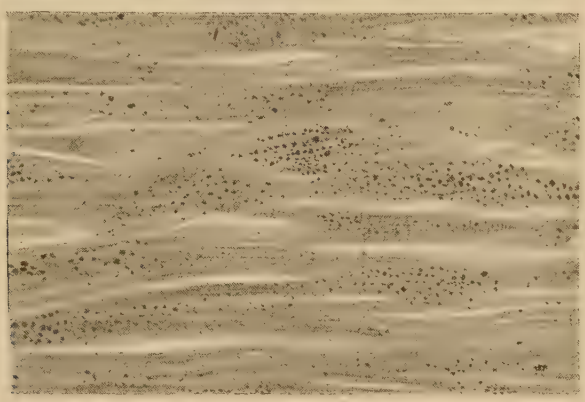
A new physical sign of rickets (*'Wien. klin. Woch.,' June* 4, 1903; *'Rev. Mens. des Mal. de l'Enf.,' June,* 1904, *p.* 284).—**R. Neurath** claims that rickets can readily be diagnosed by an examination of the hand owing to the existence of a peculiar deformity in the skeleton of the fingers. The second phalanx is hypertrophied, whilst the other two are normal, and thus form a contrast. The enlargement is chiefly on the dorsal surface, so that the deformity is best seen by looking at the hand in profile. At the level of the enlargement the skin, though normal in itself, appears stretched, and is thrown into folds only with difficulty. More rarely another deformity is present; then the first and second phalanges form a cone, whilst there is a dorso-palmar thickening of the third phalanx, so that the finger looks like a thin skittle. Occasionally the terminal phalanx has a drumstick appearance. Radiography shows that the enlargement is due to a periosteal thickening.

These changes are commonest in the first year of life and only occur after that age in severe cases. One can hardly confound the deformity with the phalangitis of hereditary syphilis, which chiefly affects the ungual phalanx, giving it the appearance of a truncated cone; in rickets it is the whole finger that is affected, becoming fusiform. The changes disappear under anti-rhachitic treatment. Most authorities—such as Kassowitz and Monti—state that digital changes in rickets only occur in the severest cases, and so are rare.

A. Ernest Jones.

Uncomplicated myocarditis in a girl in her eighth year (*'Lancet,' October* 1, 1904, p. 947).—**George Carpenter** gives the history of a child whom he admitted cyanosed into hospital with the signs of heart failure.

Her pulse was weak at the wrist and the first heart sound was not good. There was no extension of cardiac dulness to the right and no regurgitant pulse in the vessels of the neck. A few bronchitic signs were to be heard in the chest. The patellar reflexes could not be obtained, and the soft palate acted, but not freely. Her urine was nearly solid, with albumin. The temperature was 97·8° F. The diagnosis made was myocarditis. She died the following day. Autopsy showed that the cardiac valves were healthy. The right side of the heart was somewhat dilated. The heart muscle was extremely pale and friable. All the cavities were filled with blood-clots. Stained by Marchi's method, scattered areas of fatty degeneration of the cardiac muscle were demonstrated in all parts, but were chiefly noticeable in the left ventricle. The lungs were heavy and dropsical. The liver was pale. The kidneys were pale. Microscopically pigment granules of golden-yellow to black colour were found in certain areas either incorporated with the cells of the tubules or lying on the surface. The straight tubules of the kidney



Microscopic section of the left ventricle, showing fatty degeneration of the muscle (stained Marchi). Longitudinal striation of the muscle-fibres is pronounced, but cross striation where present is but faintly indicated.

contained old and shrivelled red-blood cells, forming casts there and filling many of them. The spleen and pancreas were normal. The mucous membrane of the stomach was congested and it contained a little altered blood. Carpenter calls attention to the fact that, in Vol. III of the 'Reports of the Society for the Study of Disease in Children,' pp. 170—181, and the paper which was read before the Society and published in full in 'The Lancet' of May 30, 1903, p. 1508, he drew attention in this country, under the heading of "Uncomplicated Myocarditis in Children," to the occasional occurrence of clinical examples of primary degeneration of the heart muscle in the young with all the symptoms of valvular disease and without endocarditis, of which the case quoted is an example. Long prior to this, in 1896, he had called attention to the condition in America ("Two Fatal Cases of Heart Disease in which the Cardiac Muscle was alone involved," 'Pediatrics,' vol. ii, pp. 234—238). In his other cases one, post-diphtheritic, whose cardiac symptoms were much like those of the child under discussion, recovered. Another of unknown

causation died and interstitial myocarditis was found post mortem. A third, of rheumatic origin, died suddenly and fatty degeneration of the heart muscle was found. A fourth, a boy, aged 12 months, showed extensive fibroid disease of the heart. The child died suddenly and general tuberculosis was found at the necropsy. The cause of the heart disease was not obvious and possibly rheumatism was responsible. There was no evidence of syphilis. In the present example the cause for the fatty degeneration of the heart was not certain, but he was inclined to the view that it was post-diphtheritic; at least, that appeared to him to be the most likely solution. He claimed for myocarditis, including in this term cases of fatty degeneration of the muscle-fibres pure and simple, a distinct clinical entity. He used the term "myocarditis" with intent, and not because he wished it to be understood that he considered there was anything about the condition of an inflammatory nature. For one reason it is customary at the present time in text-books on children's diseases to group such conditions under the heading Myocarditis, but he used the term chiefly because he wished the case to appear as an addendum to his recent communication on myocarditis in children. The disorder in a pronounced case, in the absence of complaints known to produce it, can be diagnosed during life; and it is a state, dangerous though it be, from which recovery can and does take place, even in a severe case, as he had more than once observed. The incidence of cardiac symptoms in association with diphtheria, influenza, scarlet fever, rheumatism, or sepsis, etc. facilitated the diagnosis. Myocarditis is likely to be overlooked in cases where the primary disorders which produce the complaint have passed unnoticed, as is very likely to occur and as a matter of fact frequently does happen, and when the patient first comes under observation as a case of heart disease, especially if the condition sometimes chances to be associated with cardiac bruits independent of valvular lesions. Of cases of temporary cardiac invalidism there must be many examples which escape detection. Now that attention is drawn to the condition it is hoped that it may bring forth valuable observations in the future on an important subject which needs further and more extended investigation.

THEODORE FISHER (Bristol).

Estimation of proteid in human milk (*'Journ. of Obstetrics and Gynæcology of the British Empire,' April*, 1904, *p.* 344).—**Sikes** recommends the follow process: "1 c.c. (or better 1 gramme) of milk is put into the glass tube of a centrifugal machine; to this 14 c.c. of absolute alcohol is added, and enough dilute acetic acid to render it faintly acid; it is then heated in a water bath till it begins to boil, then rapidly centrifugalised, the supernatant liquid (if it be not quite clear) poured off through a small, good filter-paper (this filtrate, as it cools, gives a whitish deposit of fatty substances, and the solution contains nearly all the sugar); 14 c.c. of alcohol is again added, shaken up, boiled, centrifugalised, and the supernatant liquid filtered, if necessary, as before; this is then repeated a third time; finally, any traces of proteid in the filter-paper are washed off with some hot absolute alcohol, mixed with the precipitate, which is then transferred to a platinum capsule, evaporated over a water bath, and dried at 100° F., weighed, and the residue incinerated; the weight of capsule plus ash deducted from the weight of capsule plus proteid, etc., gives the amount of proteid present in the quantity of milk taken." The results of fourteen consecutive estimations made on the third and the twelfth day after confinement were: maximum 2·95 on ninth day; minimum 1·20 on eighth day;

average 1·84 per cent. Taking the specific gravity of the milk at 1030, the corrected average is 1·79 per cent. The process takes less than an hour. The necessary apparatus consists of a balance, centrifugal machine, water bath, and drying oven. It can be used for the estimation of albumin in urine. EDMUND CAUTLEY.

Congenital word-blindness (*'Lancet,' September* 17, 1904; *'La Clinique Infantile,' October*, 1904).—**Sydney Stephenson** reports two cases of this condition, which he considers is not so rare as has been suggested, though many may escape observation. The first was in a boy, aged 9 years, who had considerable difficulty in spelling and writing, though he was exceptionally intelligent in other matters. After special education the power of reading improved, and he was even able to spell Latin words; unfortunately, he died at the age of 14. The second case was more severe in type; it affected a boy, aged 10 years, who showed other nervous symptoms, especially spasmodic movements of the face and neck. He was able to read, but with great difficulty, and could not read his own writing with any fluency. He could not copy a printed page, but was gifted with a very retentive memory of what was said to him. In both these cases the parents and relations were healthy and intelligent in all respects. The vision of the patients was normal. The general prognosis of these cases is a slow improvement with careful training. J. PORTER PARKINSON.

On the abuse of milk in the chronic gastro-intestinal disorders of children after weaning (*'Gazette des Hopitaux,'* 1904, *p.* 129).—**Billon** has a suggestive article on this subject. He thinks that a strict milk diet often does more harm than good in these cases. The milk coagulates in the stomach and finally reaches the colon imperfectly digested setting up acute colitis. This is more common in well-cared-for children than in the poor. **Bipart** (*'Jour. de Paris,'* 1903) says that these patients present three clinical types, which may merge into each other. In the first the child suffers from chronic gastro-enteritis with constipation. The stools are hard scybalous, and covered with mucus. Evacuation is extremely painful, and there is a tendency to the production of hæmorrhoids, prolapse of the rectum, and fissure of the anus; there may be spurious diarrhœa. The child is anæmic, the limbs wasted, the complexion earthy, the abdomen soft, though full. The stomach is distended by gas, the liver is large. A cord-like mass is felt in the upper part of the descending colon. The urine contains indican and often albumin. The red corpuscles are diminished to 2,000,000 per cmm. The second type begins as acute enteritis, with green diarrhœa, the stools containing coagulated particles of undigested milk. If neglected, or if treated by milk diet, the enteritis becomes chronic, with mucus in the stools. The abdomen is distended and tender. This is soon followed by constipation. The last type presents the picture of acute gastro-enteritis. If milk diet is given, vomiting continues, the breath is fœtid, "with a butyric odour." Convulsions may occur. *Treatment.*—(1) In the acute stage, for twenty-four hours give water only. Then give farinaceous soups and diuretic drinks; after a time soups made with fresh meat. (2) In the chronic stage two principles should be kept in view: to check the diarrhœa, and to prevent intestinal decomposition. If the child has only just been weaned, let it return to the breast. Otherwise give soups made with boiled or sterilised milk. Kifir may also be used. Food should not be given more than four times in the twenty-four hours. General hygienic

measures should also be attended to. The results of this treatment are said to be good. The pathology of the condition is fully discussed, and also the curative action of the foods recommended. S. H. Bown.

Surgery.

Gonorrhœal arthritis secondary to conjunctivitis in a new-born child (' *Riv. di Clin. Ped.*,' *June*, 1904).—**C. Comba**. The mother, a primipara, was affected with an abundant muco-purulent genital discharge, and the infant during the first days of birth had an intense conjunctivitis, and on account of the puerperal fever of the mother was nourished by sterilised cow's milk, and subsequently by a wet-nurse. It did not thrive, and developed swellings of the right wrist and knee and of the left elbow, which were tender but not reddened. On admission to the clinic when 37 days old, gonococci were detected in the conjunctival secretion, and the right knee, which fluctuated, was twice punctured, but only on the second occasion was one example of the gonococcus detected in the milky, glutinous fluid drawn off. Solution of protargol 1 per cent. was used for the eyes, and inunction of a 10 per cent. oily solution of methyl salicylate to the joints. Cure resulted in a month. The author thinks that the scarcity of gonococci in the joint is attributable to the length of time elapsed since the first infection. Vincent Dickinson.

Diphtheritic stenosis of larynx in children under 2 years and a proposal for a different method of treatment (' *Riv. di Clin. Pediat*,' *July*, 1904).—**D. Pacchioni** considers that in the first year of life especially the mortality of tracheotomy is greater than that of intubation, but at this age also the mortality of intubation is much more than in older children, chiefly from pneumonia and laryngeal ulceration. His idea was to leave the tube in the larynx for as short as possible a time sufficient to clear the respiratory track from membrane and to overcome spasm, so as to diminish as far as possible the danger of pneumonia and ulceration of the larynx. Asphyxia in these cases being due either to the presence of membrane, spasm of the glottis, or swelling of the mucous membrane, intubation provides a means of counteracting them even by a brief stay of the tube in the larynx. The author tried the effect of a few hours of intubation in order to minimise as much as possible the consequences arising from a protracted stay of the tube in the larynx. As a criterion for the duration of the intubation he looked to the quantity of membrane or mucus expelled and the more or less easy manner of breathing after the operation. In those cases where little membrane was expelled he left the tube in two to four hours, when there was less satisfactory result, six to ten hours. These short intubations enabled the nourishment of the child to be partially suspended during that period, so limiting one of the causes of pneumonia, only small pieces of ice or a teaspoon of water occasionally being given. O'Dwyer's new model in ebonite was used with a thread attached and the patients were kept under the influence of bromide and serum; therapy resorted to freely. Short and repeated intubations do not exclude the necessity for tracheotomy to which the author resorts if after three or four days of short intubations the child still has attacks of asphyxia, or as soon as the tube gives the least evidence of commencing ulceration. His results were of 37 cases: intubation 19, cases with 3 deaths and 15 recoveries; secondary tracheotomy, 18 cases with 7 deaths and 11 recoveries. Vincent Dickinson.

Cases of macrodactyly (*'Nouvelle Iconographie de la Salpêtrière,' No.* 1, 1903).—**Félix Lejars** reports the case of a girl aged thirteen in whom the middle finger of the left hand was large at birth and grew out of all proportion to the other fingers. It was 15 cm. long and 12 in circumference. It so impeded the use of the hand that he amputated through the metacarpal bone. **Cayla** (*'Nouvelle Iconographie de la Salpêtrière,' No.* 1, 1903) also reports a case of macrodactyly in a boy of seventeen. All the right upper limb was hypertrophied, but more especially the three outer fingers. Other stigmata were present, *e.g.* facial asymmetry, strabismus, high-arched palate. A. Ernest Jones.

Double ablepharon (*'Indian Medical Gazette,' March,* 1904, *p.* 93).—**E. H. R. Newman** reports the rare case of a Hindoo male infant, aged one year, who presented no trace or suggestion of a palpebral fissure on either side. Eyebrows and nasal bones were poorly developed, and the face presented an extraordinary mask-like appearance. The child could distinguish between light and darkness. On operating a very rudimentary trace of a conjunctival sac was found at the lower and outer part. The cornea presented an opaque ground-glass appearance; its curvature was irregular and bulging. No trace of lachrymal apparatus was found. The cornea ulcerated and eventually sloughed, the wound contracting and leaving a granulating sore. No operation was attempted on the left eye. In this case no true eyelids existed at all. Edmund Cautley.

Pneumococcic peritonitis in children (*'Med. Rec.,' Feb. 13th,* 1904). [*Absts. from 'Rivista de Clinica Pediatrica' Dec.,* 1903].—**Francisco Gaite** comes to the following conclusions with regards to pneumococcic peritonitis: (1) It is most common in childhood; (2) the female sex is more predisposed to the disease; (3) there are various pathogenic variations of the disease: the primary seat of inoculation may be in the intestines, pleura, female genital tract, and probably also may spread from the blood; (4) the prognosis is good when a localised infection of the peritoneum is treated rarely by operation. In cases of diffused peritoneal infection the prognosis is doubtful. P. Lockhart Mummery.

Hernia in young children (*'Med. Record,' February* 13, 1904).—**W. B. de Garmo** of New York. In discussing this question the author points out the interesting fact that hernia in infants is much more frequently associated with gastro-intestinal disturbances than is the case with adults. He points out that infant gastro-intestinal troubles frequently disappear as soon as an existing hernia has been properly retained. He favours the treatment by trusses, and states that the majority of hernias in infants can be cured by truss treatment alone. This is contrary to the experiences of most other surgeons, and does not take into account the possibility of hernia developing again later on in life. He considers the operation very safe and entirely satisfactory, and gives the following indications for operating: (1) Strangulation; (2) all cases not controlled by a truss; (3) occasional protrusion with threatened strangulation; (4) when wearing the truss causes pain; (5) children that cannot be brought regularly for attention; (6) in all cases of femoral hernia; (7) in all cases of children over 7 years. With regard to the age at which operation should be performed no age limit is given. The record for operating for hernia at an early age would certainly seem to have been reached by a surgeon quoted by Dr. de Garmo, who

operated on a child for hernia two weeks before the normal termination of intra-uterine life, the child having been born at the eighth month.

P. Lockhart Mummery.

The operative treatment of hernia in infants and young children (*'Brit. Med. Journ.,' Oct. 1st,* 1904).—**Harold J. Stiles.** In discussing the vexed question of operation *versus* truss treatment for the cure of hernia in children, Mr. Stiles, after an experience of 360 cases, strongly advocates operative treatment in all cases. He emphatically corroborates the opinion already expressed by other writers upon this subject, that even when the truss treatment is successful in getting rid of the hernia, it leaves an unobliterated sac which frequently results in a recurrence of the hernia later on in life. He quotes Coley's statistics to show that in one third of all cases of hernia in adults there is a history of hernia in infancy. The operation which he performs is similar to that originally described by Sir Mitchell Banks. He advocates sewing up the ring by a single catgut suture. In children up to the age of three he advocates a rather novel form of after-treatment. No dressing is applied to the wound at all, but it is left exposed and merely dusted with boracic acid. The child is fixed down in the bed, and a wire cage is placed over the lower part of the body to prevent any of the clothes coming into contact with the wound. He speaks very highly of this form of after-treatment in infants, and says that since adopting it he has come to consider the operative treatment of hernia as less trouble than a circumcision. In discussing the frequency of strangulation in infants, he says that of the whole 360 cases it was present or threatening in 8·3 per cent. He gives a most necessary and emphatic warning against the use of taxis in dealing with cases of strangulated hernia in infants. Mr. Stiles found the cæcum in the sac of the hernia in 7 per cent. of his cases, and he believes that this variety of hernia is more liable than others to become irreducible. He advises removing the appendix when it presents as a precautionary measure against future trouble. He records a mortality of 1·4 per cent. or five deaths. Of these, previous taxis resulting in damage to the bowel appeared to be the cause of death in three cases. One child died under the anæsthetic, and one from sepsis. With regard to the age at which the operation should be performed, Mr. Stiles does not think the age is of much consequence, but he prefers to operate at about the age of six months.

P. Lockhart Mummery.

Report on two children operated upon by Lorenz (*'Med. Record,' March* 5, 1904; *from 'Journ. of Amer. Med. Assoc.,' February* 27, 1904).—**H. M. Sherman.** In one of the cases the thigh was flexed upon the pelvis and abducted till it lay in the frontal plane of the body. No rotation of the limb was apparent. The leg was flexed on the thigh and could not be extended. The limb was, in fact, in the same position as when originally put up in plaster by Lorenz himself. The condition of the limb was not favourable to stable support, and the child had to be re-operated upon to allow it to walk. The head of the femur was in a subcutaneous position in the outer part of Scarpa's triangle and was not in the normal relation to the acetabulum. In the second case the head was also in the outer part of Scarpa's triangle and subcutaneous. The child could not walk after removal of the splint, though it had been able to do so previously. Mr. Sharman did not consider that Lorenz had in any way benefited these cases.

P. Lockhart Mummery.

Otology, Rhinology, and Laryngology.

Scarlatinal panotitis; exfoliation of a portion of the labyrinth; radical operation (' *Med. Rec.*,' *January*, 1904; ' *Journ. of Laryngol.*,' etc., *September*, 1904).—**C. Koller** reports the case of a female child, aged 4 years, who was taken suddenly ill with vomiting and fever; the vomiting lasted three days. A scarlet fever rash developed fully, and was followed by diphtheria. On the eighth day of the illness deafness and otalgia on both sides were noticed, and were followed by profuse aural discharge. At the end of four weeks, when the child was allowed up, staggering was observed. Two months after the illness she was admitted into the hospital. There were granulations in the tympanic cavities, and bare bone was noticed on the left side. A radical operation was performed on this ear; the antrum and other cavities were found full of granulation tissue and pus. A loose sequestrum was removed; it was found to consist of the superior and external ampullæ, and parts of the superior and external semicircular canals. A second sequestrum was also removed, consisting of part of the annulus tympanicus. The child made a good recovery, but did not regain the hearing on this side. RICHARD LAKE.

Two cases of cerebral abscess, due to ear disease (' *Journ. of Laryngol.*,' *September*, 1904).—**De Greift** reports these cases, the first of which was that of a child, aged 12 years, who had suffered with an otorrhœa of four years' standing. The child was attacked with sudden pain in the affected side. This was soon followed by fever, together with brain disturbance. On opening the antrum, the roof of the tympanum was found to be carious, and a large cerebral abscess was opened and drained. A second abscess was found a few days later, and also treated surgically. Recovery was complete. The second case was that of a child, aged 13 years, with purulent otitis media, which had been neglected. Later facial paralysis and pain ensued. A large cerebral abscess was found at the time of operation, which it was believed was connected with the lateral ventricle. Recovery was complicated by the formation of a large hernia cerebri, but was eventually complete. RICHARD LAKE.

A case of temporo-sphenoidal abscess operated upon seventeen years ago (' *Journ. of Laryngol.*,' *September*, 1904).—**T. Barr** presented a case at the Otological Society of great Britain of a man, aged 27 years, who came under his care in January, 1887. The patient was then 10 years of age, and presented all the classical symptoms of temporo-sphenoidal abscess on the right side. Prof. Macewen operated on the boy, opening and draining a large temporosphenoidal abscess, and the case was reported in March, 1887, in the 'Lancet.' The patient is now married, and has two healthy children. RICHARD LAKE.

Naso-labial eczema (' *Archives de Laryngol., d'Otologie, et de Rhinologie*,' *May and June*, 1904).—**Sota y Lastra**. This author states that this affection is most common in children between the ages of 6 and 10 years, and boys of from 13 to 15 years. It also occurs fairly frequently in females aged 17 years and upwards. He says that sufferers from this malady usually exhibit the scrofulous type of beauty—that is, an elegant figure, oval face, rosy complexion, large and expressive eyes, long eyelashes, abun-

dant eyebrows, with fine and glossy hair. He describes with great minuteness the course of the disease and its pathology. He says that patients are rarely seen early, but usually not until the disease has existed for some time. He divides the affection into three stages, common to all forms of eczema. The prognosis is very favourable if the treatment adopted is suitable. Occasionally granulation tissue will appear at the entrance to the nose, and must be removed, and sometimes, when the disease has existed for some years, it may simulate rhinoscleroma. It is also liable at an early stage to be confused with labial herpes, but the vesicles in eczema are very small compared with those of herpes. As regards the treatment, the author says that it is necessary to attend carefully to the dietary. The nourishment should be frugal; the patient should abstain from highly seasoned foods and irritating substances, alcoholic drinks, nuts, strawberries, green fruits, and other indigestible aliments. In order to combat the gastro-intestinal catarrh which is usually present laxatives should be ordered from time to time. The mouth should be cleansed with a boric acid mouth-wash; the lips should be sponged with a solution of 1 in 1000 corrosive sublimate and tampons of cotton-wool soaked in boracic solution. The crusts should not be forcibly removed, but allowed to fall off naturally. When this occurs, the surface is dressed with coal-tar powder. In a very chronic case the author uses the following ointment: Cacao-butter, 4 grm.; oil of sweet almonds, 1 grm.; tartaric acid, 0·35–0·30 grm. If fissures appear during the course of healing, they should be touched with nitrate of silver, or a 30 per cent. solution of chloride of zinc. If the eczema becomes impetiginous, and the ulcerations become covered with granulation tissue, a concentrated solution of chloride of zinc is applied, after a slight scarification.

RICHARD LAKE.

Softening (breaking down?) of a cicatrix over the mastoid in the course of scarlet fever (*Archives de Laryngol., d'Otologie, et de Rhinologie,' May and June,* 1904).—**A. Trifiletti** describes the case of a child aged 8 years, with an abnormal development of the bony system. Until April, 1903, he had never had any serious illness. He then had an attack of acute left otitis media, which was followed by mastoiditis, with œdema in the region of the mastoid. As all attempts to control the disease were unsuccessful, the mastoid was opened. Nothing very remarkable was discovered at the time of operation. Complete healing resulted in about a month's time; the hearing was quite normal, and only a linear cicatrix was visible. Seven months later—that is to say, in January, 1904—the little patient had scarlet fever, but there was no special involvement in the naso-pharyngeal region or throat. Two days after the onset of the fever a considerable amount of inflammation was noticed in the skin surrounding the site of the old operation wound. This was accompanied by intense irritation, and was treated by cold compresses of weak sublimate solution. On the second day after these were applied a small vesicle appeared in the centre of the post-auricular swelling, so linseed poultices were applied; the vesicle burst, and pus escaped. On the following night the fever moderated. On the third day pus issued from the external auditory meatus. On examination the tympanum was found to be considerably congested, especially in the superior posterior part; but, although no perforation was visible, there was probably a small sinus leading into the mastoid antrum. Antiseptic irrigation and plugging with iodoform gauze resulted in a complete cure by 10th February.

RICHARD LAKE.

Reviews of Books.

ANNUAL REPORT OF THE MEDICAL OFFICER OF THE LATE LONDON SCHOOL BOARD FOR THE YEAR ENDED MARCH THE 25TH, 1904 (*continued*).

As was mentioned in the first part of this review, the greatest advance in knowledge recorded in the Report under consideration refers to the two diseases diphtheria and measles; for the work on which this advance is based we are indebted to Dr. C. J. Thomas. In connection with *diphtheria* the following are the questions dealt with: 1. Age incidence in board schools. It is found that the disease only tends to spread amongst children who are between their fourth and seventh birthdays. This is accounted for by assuming that such children have lost the congenital immunity present in infants and have not yet acquired the later immunity found in older children, that which is perhaps due to repeated sub-pathogenic doses of bacilli. 2. Incidence in children generally. Unfortunately, this has not been ascertained except in selected schools; *i.e.* only schools in which there was reason to suspect infection, such as by the presence of recurrent cases, have been examined. Of 758 children examined bacteriologically, 7·6 per cent. had Klebs-Loeffler bacilli and 28 per cent. had bacilli of the Hofmann group—pseudo-diphtheria bacilli. This percentage would be lower still if the schools were examined systematically, apart from the presence of epidemics. Such an investigation should yield valuable results, had but the Board a sufficient staff to carry it out. The results obtained contravene those previously obtained by other observers in London, a contradiction perhaps due to the insufficient differentiation of bacilli in the older results. 3. Pseudo-diphtheria bacilli. It is most interesting to note that these bacilli run parallel with the true diphtheria bacilli, the two kinds waxing and waning in frequency together with great regularity. We would suggest that in the next Report the relationship be indicated more exactly by incidence curves. It is considered that these pseudo-diphtheria bacilli may cause slight sore throat, but that they are totally distinct from the Klebs-Loeffler. The reasons for this latter faith are not given, though they become more necessary in view of the recent French observations showing that typical paralysis may follow such infection. The value of the observations here recorded is lessened by the fact that in the large majority of instances time has not been found to employ any differential tests beyond that of Neisser's. 4. Mode of spread. Dr. Thomas lays great stress on the practical importance of what he terms "carrier" cases, *i.e.* apparently healthy children who harbour bacilli and form foci of infection. There is no way of detecting such cases save by systematically swabbing the throats of all the children in the school, but some brilliant results have been thus obtained. Schools where the disease has been endemic, resisting all efforts at disinfection, have been at once rendered disease-free by the discovery and isolation of one or two "carriers." The negligence of allowing cases of diphtheria to return to school without seeing that they are bacteriologically free is also referred to, as it is evident that even at the present date there are still practitioners who rely purely on clinical evidence in such cases. It has been clearly shown that for months after an illness virulent bacilli may linger in the nasal discharge and throat. 5. School closure. As is logical, it is pointed out that this procedure should never be carried out on account of

diphtheria, seeing that the detection of carrier cases is absolutely efficacious, while the dissemination of the disease is only hastened by closing the school and sending such cases free amongst the community. 6. The lack of facilities for bacteriological examination in many parts of London and the inadequacy of our present isolation arrangements are also referred to.

Measles.—In this connection the most interesting question is that of school closure. It has been shown that if no such measures are taken what happens is this: measles breaks out, probably in several cases about the same time; these at once infect a large number of children who fall ill in twelve days' time; after this nothing further occurs—*i.e.* all the susceptible material is exhausted in the second "crop"; in other words, all the children who have never had the disease get it when first exposed to it. This is in accordance with what we know clinically of the disease, that children are more uniformly susceptible to it than to, say, scarlet fever. Now, it is clear that school closure, to do any good, must be carried out before the sowing of the second crop, immediately on the occurrence of the first case in a susceptible class. If it is carried out later, the mischief is done and the result is the same as if the school were kept at work. Application of this principle costs 63 attendances per case of measles, whereas formerly each case cost 135 attendances.

It is on the subject of *ventilation* that we find the most disappointing section of the Report. Anyone has but to enter one of the best ventilated schools in London to perceive the unspeakably bad conditions under which the teacher and children have to work, and to realise how ideally adapted such conditions are for the conveyance of all forms of colds and other respiratory infections. That this is not to be wondered at is clear when we find the medical officer writing calmly that 130 cubic feet of space is the correct allocation to every child, that the ideal to be aimed at is the keeping of the carbon dioxide below *ten* parts in ten thousand, and that, "judged by this standard, the majority of schoolrooms show excess." That a growing child, not to speak of the teacher,—a child whose respiratory tract is in a state of chronic infection—should be judged to require one tenth the old-fashioned, out-of-date standard of cubic space seems to us incomprehensible.

Other important questions, such as the deliberate production of myopia by our faulty methods, the non-correction of refractive errors, the new work done on the subject of mentally defective children, and the interesting Mannheim scheme drawn up by Mrs. Berry, we have no space to consider at present. In conclusion, we heartily congratulate the authors of the Report on the mass of work they have been able to accomplish under circumstances the reverse of encouraging, and look forward with great interest to the further development of the lines they are beginning to lay down.

A. Ernest Jones.

Health and Disease in Relation to Marriage and the Married State. Edited by Professor H. Senator, M.D., of Berlin, and S. M. Kaminer, M.D., of Berlin. Translated by Dr. Joseph Dulberg, of Manchester. Publishers: Rebman, London. Price 30s. net.

The sale of this work is confined to the medical and legal professions, as it deals in detail and exhaustively with the most unpleasant topics that can engage the serious attention of those who have the welfare of the human race at heart. The eminence of the collaborators is a guarantee that each subject is treated with the least possible grossness. With regard to the

marriage of those who are diseased, it should be dissuaded from when their lives, even with increased premiums, are not insurable. Climate and race as affecting marriage is one of the subjects that specially merit perusal, though it is rather a counsel of perfection, as the time is slow in coming when prejudice will be dead and reason as exemplified by the teachings of the medical profession will become the leading element of the nations. The work, though fascinating, is not pleasant reading, but is of distinct value as a book of reference T. P. Beddoes.

New Inventions.

The Glas-Sedlbauer Portable Lamp for the Light Cure of Lupus.

This is a new hand lamp on improved principles. It is claimed that it performs the work of the Finsen lamp at nominal working expenses and will be sold at a price which will bring it within the reach of all practitioners.

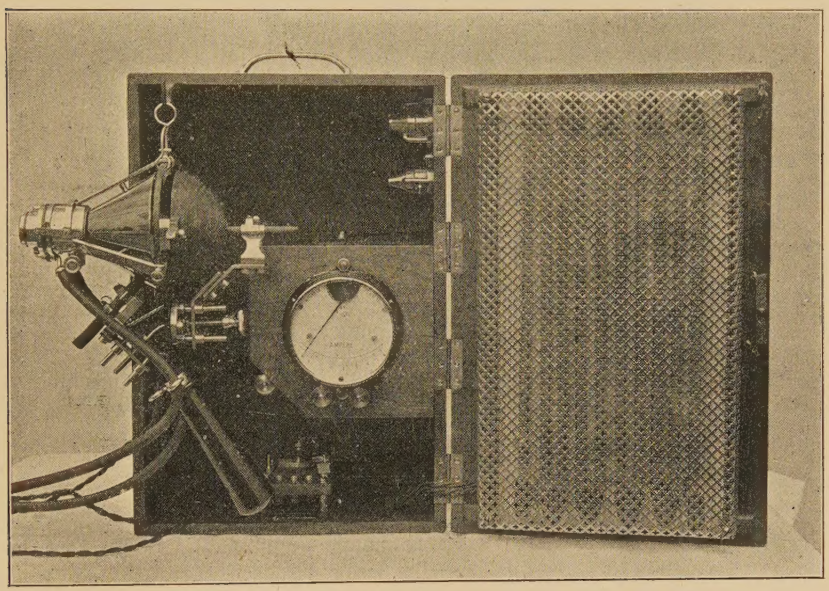


Fig. 1.—Glas-Sedlbauer portable lamp, ready for use.

Fig. 1 shows the lamp ready for use away from home, and Fig. 2 represents the lamp more in detail and with a small lens attached. The lenses, which vary in size for different parts of the body, are three in number; they can be easily and expeditiously changed when required. A most important feature is that these lenses, which are perfectly cooled, neither crack nor wear out in operation—a very expensive feature of other lamps.

A much smaller amount of electricity is consumed than with the Finsen lamp, and wherever electric light and a water tap are at hand there the light can be set in operation by a novice in electrical matters in less than five minutes.

Dr. Jesioneck, when drawing attention to his recent experiments at Munich, in the 'Munich Medical Journal,' reported that "the Glas-Sedlbauer lamp

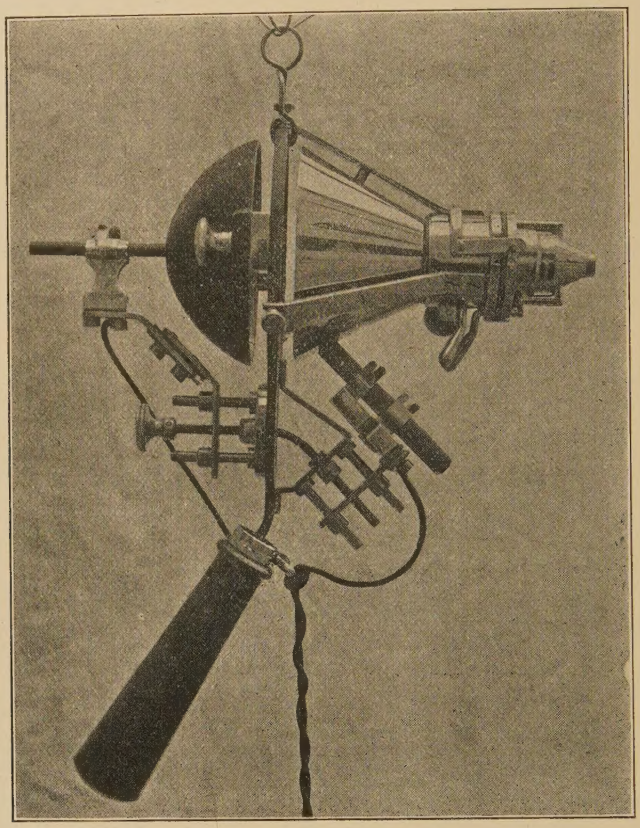


Fig. 2.—Glas-Sedlbauer Lamp, with small lenses. The lenses can be easily varied in size.

took the place and did the work of the Finsen lamp, and the yield of light by this lamp was five times greater than by the lamps now in use."

The reactions produced by the ultra-violet rays of this lamp on healthy and also on diseased skin correspond in quality with those of the Finsen lamp. The therapeutic results on lupus will quite safely compare with those of the Finsen lamp.

The lamp will be shown in operation at the meeting of the Society for the Study of Disease in Children, on Friday, November the 18th, at 5 p.m., at No. 11, Chandos Street, W.